

“Going through the transition from being an end user to sort of the provider”: Making sense of becoming a mental health peer support worker using Interpretative Phenomenological Analysis

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Thesis Abstract

Introduction: This thesis explored National Health Service (NHS) Mental Health (MH) Peer Support Workers' (PSWs) experiences of transitioning from their own lived experiences of MH difficulties to supporting other people with their MH problems. Existing literature is scarce, particularly in the United Kingdom (UK). When it is available it oversimplifies the transitional process by failing to offer more than general descriptions of benefits and challenges to enacting the role.

Aims: The purpose of the study was to explore how PSWs made sense of their experience of transitioning from their own lived experience of MH difficulties to providing a service to support others with their MH difficulties.

Methods: Single-site ethical approval was gained to conduct the study in one NHS Trust. All PSWs within the service were approached by the Peer Support project coordinator. Semi-structured interviews were conducted with seven participants. Interviews were transcribed verbatim and analysed using an interpretative phenomenological analysis framework.

Results: Analysis of transcripts yielded three superordinate themes. They were interpreted as interdependent with interrelating subordinate themes. The superordinate themes loosely reflected a time dimension of preconceptions before entering the role, actively making sense of the role in the here-and-now and future aspirations of the role. The first, *fluctuating identities*, detailed participants experience of a changing social self and a feeling of reconnecting, recovering and taking control. What constrained this were the difficulties with managing multiple identities. The second, *PSW role*, specified the understanding of what provided certainty in the role and where there was role vagueness and difficulties. Participants also detailed the complexities around boundaries and disclosures. Finally, *organisational culture*, outlined participants desire to change the NHS system. Supporting attitudes and barriers were described, at an individual, service, organisational and societal level.

Discussion: The findings were compared to studies conducted in the areas of peer support, role transitions and identity. This research captured the complex

and variable process of the transition, involving a number of inter-relating factors that impacted on an individual's personal, interpersonal and collective identities. Participants highlighted the juxtaposition of the PSW identity being both emancipating and constraining whilst detailing the personal impact and attempted resolutions.

Conclusion: The current research has clinical implications for the MH system, in that it has a role in practically supporting interprofessional working whilst addressing possible stigma attached to the PSW role. This research advocates for PSW training to be tailored to individual need, and flexible support offered throughout the process to both PSWs and the teams receiving PSWs. Finally, psychological interventions (e.g. self-narrative identity work), could help newly appointed PSWs to articulate and co-construct their identities during the transition; contextualising professional, personal and practice development. Methodological considerations are discussed, such as retrospective data collection, difficulty in recruiting a homogenous sample and the reliance on a specific transitional point. Suggestions for future research focus on the need for further longitudinal studies to better understand the enactment of the role. It may also be beneficial to explore the experiences of recipients of peer support and other professionals who work alongside PSWs.

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Statement of contribution

1. Project design:
Gemma Dyble (with supervision from Anna Tickle and Christine Collinson)
2. Applying for ethical approval:
Gemma Dyble (with supervision from Anna Tickle, Christine Collinson and the Trent DClinPsy Service User and Carer Panel)
3. Writing the literature review:
Gemma Dyble (with supervision from Anna Tickle and Christine Collinson)
4. Recruiting participants:
The Peer Support Coordinator disseminated information packs to potential participants
5. Data collection:
Gemma Dyble
6. Transcription:
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7. Analysis:
Gemma Dyble (with supervision from Anna Tickle)
8. Write up:
Gemma Dyble (with supervision from Anna Tickle and Christine Collinson)

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Systematic Review

The role of a paid peer support worker in a mental health setting: A systematic review of the literature

Abstract

Background: The implementation of formal peer support projects has been championed as a way of supporting employment and recovery from mental illness. Recovery is a central focus of UK mental health policy, guidelines and practice.

Aims: To conduct a systematic review appraising research that incorporates the perspective of employed formal peer support workers in mental health settings. An additional aim of the review was to evaluate the methodology of each study in terms of potential threats to validity.

Method: Electronic databases (1990-present), reference lists and grey literature were searched to identify relevant articles. An evaluative tool was implemented and a narrative checklist when extracting the data. Seven studies were included in the review. Five studies were service evaluations.

Results: Whilst most of the studies reported that the programmes were beneficial, few presented data using rigorous research methodologies to support claims. Overall, the use of theoretical underpinnings to inform formal peer support was limited.

Conclusions: There is a lag between the development of theoretical understanding of peer support in the mental health setting and empirical validation of the approach. The review recommends future studies use robust methods to develop the evidence base relating to peer support.

Declaration of interest: none

Keywords: Mental health; Peer support; Training; Employment; Review

Introduction

1.1 *What is peer support?*

Formal (intentional or organised) peer support in mental health settings is a comparatively new trend, beginning in the 1990s (Carlson et al., 2001) but has recently gained significant attention as a valuable component of mental health recovery-orientated service delivery (Moll et al., 2009).

Peer support can be considered to provide psychosocial, emotional and practical support. It has been viewed as individuals with similar life experiences relating and offering authentic empathy and validation (MacNeil & Mead, 2005). There is a developing movement in mental health care towards recruiting individuals with lived experience of mental health as peer support workers in order to support current 'service users' with their recovery process (Richard et al., 2009).

For the purpose of this review, the broad term *peer support workers (PSW)* have been used. However, *peer*, *provider*, *support worker*, *specialist*, *consumer counsellor* and *trainee* are all terms that describe roles in the mental health setting whereby personal experience of mental illness is required.

1.2 *Historical context*

Peer support initiatives have traditionally taken place outside the mental health setting and have generally operated as self-help groups (Salzer et al., 2010). In the 1980s, the NHS management enquiry recommended that consumers of health care should be involved in future developments and evaluation of services (Griffiths, 1983). The principle of service user involvement is now generally supported and explicit in most statutory and voluntary initiatives (Joseph Rowntree Foundation, 2003) and endorsed across varying levels of service relations; from individual encounters (e.g. Scottish Executive Health Department, 2006) through to service management (e.g. Department of Health (DoH), 1999) and strategic planning both

locally (e.g. DoH Social Services and Public Safety, 2000) and nationally (National Institute of Mental Health in England, 2007). Section 242 of the consolidated NHS Act (DoH, 2006) makes it a legal requirement for NHS trusts, primary care trusts and strategic health authorities to involve patients and the public in planning, operation and development of services.

Further development of service user involvement has seen service users providing services within mental health settings. In the last twenty years peer-support services have substantially developed across the United States (Campbell & Leaver, 2003) and have now spread to the UK (Woodhouse & Vincent, 2006; Ley, 2010).

1.3 Formal peer support and training programmes

According to Woodhouse and Vincent (2006) there are four main models of formal peer support: user run drop-in, formalised peer specialists, training programmes for peer specialists, and peer education. This review has concentrated on formalised peer specialists.

It has been argued that peer support services share a number of common values (Clay et al., 2005). The Consumer Operated Services Program (COSP) set up to evaluate peer-run programmes in America (Clay et al., 2005) developed a list of common ingredients or principles, found to underlie the different programmes (Campbell, 2008). COSP's critical ingredients are based on the Fidelity Assessment Common Ingredients Tool (FACIT), developed by mental health consumer providers (Clay, 2005). These principles, in particular the peer principle and helper principle have been considered the cornerstones of PSW and have been incorporated into much of the research supporting the efficacy of formal peer run services (Woodhouse & Vincent, 2006). The two principles have emphasised the equality and reciprocity of support and the understanding that helping others in their recovery, provides further support for personal recovery.

The concept of recovery from mental illness is a relatively recent development (Anthony, 1993). Although opinions about recovery are wide-ranging, recovery is a central focus of mental health policy, guidelines and framework (DoH, 2009). One recovery-orientated approach is linked to recovery and economic independence. Warner (2010) terms this “social recovery” (p.3) and provides evidence on a macroeconomic and individual level to support the ethos that employment is an integral part of recovery from mental ill health. The government’s vision for mental health care states that “all mental health services will be expected to recruit and train service users as part of their workforce” (DoH, 2001, p21). PSW is one way of incorporating the aims outlined by the governmental policies.

In 2008 the Scottish Government’s Mental Health Division in partnership with the Scottish Recovery Network, piloted formalised peer support schemes in five Health Board areas. PSW were trained and employed within NHS teams (McClean et al., 2009). In England there are currently pilot PSW schemes in various NHS trusts. East London NHS Foundation Trust has a two-year project funded by the National Institute for Health Resources (NIHR) to assess whether peer support provided by service users is effective (City University London, 2010). Pilot Peer Employment projects are currently based in Nottingham Healthcare Trust and Cambridge and Peterborough NHS Foundation Trust. The aim is for the workers to share their experiences to help others begin their own recovery (Cambridge and Peterborough NHS Foundation Trust, 2010).

1.4 What research has been conducted on providing peer support?

Although developing, there is a growing body of national and international research which promotes the value of peer support as good evidence based practice. Simultaneously, extensive research is beginning to outline the barriers and question its effectiveness. Doughty and Tse (2010) appraised the evidence from controlled studies for effectiveness of consumer-led mental health services, including peer support services. In relation to reduced hospitalisation, employment and costs of services they found equally positive outcomes compared to traditional services.

Furthermore, two literature reviews (Davidson et al., 1999; Solomon & Draine, 2001) outlined preliminary evidence to support the effectiveness of peer-run support services using a quantitative approach.

There have been studies outlining the uniqueness of peer support provision including a project which incorporated a non-hierarchical and non-medical approach (Campbell, 2004). When measuring self-esteem and self-efficacy, Bracke et al (2008) found that providing peer support was more beneficial than receiving it. Personal benefits gained through providing peer support have suggested it facilitates recovery, fosters social approval, professional development, and mutual support and provides financial rewards (Mowbray et al., 1998, Salzer & Shear, 2002). Helping others has been shown to increase feelings of competence and meaning (Skovholt, 1974). Nevertheless, studies have also demonstrated that providing support can be harmful and lead to negative emotions and burnout (Bracke et al., 2008).

Most of the studies outlined have been descriptive and tentatively conclude that PSWs find the role to be beneficial. Training or how the “critical ingredients” are incorporated into the studies is rarely discussed. Often service level implications have been considered but links between peer support theories and practice have not.

Existing systematic reviews conducted within the field of service user involvement and peer support within the mental health setting have been outlined in table 1.

Table 1: Systematic reviews already conducted within the field of service user involvement and peer support within the mental health settings		
Author	Title of the systematic review	Topic covered
Keating et al (2006)	Research Priorities for service user and carer-centred mental health services: A synthesis of the literature	Research/service user and carer involvement
Simpson et al (2002)	Involving users in the delivery and evaluation of mental health services: systematic review	Delivering and evaluating services/service user and carer involvement
Repper et al (2004)	A review of the literature on user and carer involvement in the training and education of health professionals	Training and education/service user and carer involvement
Davidson et al (1999)	Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence	Randomized control trials, comparing conventional care when provided by peers Vs non-peers
Doughty et al (2010)	Can Consumer-Led Mental Health Services be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries	Compared consumer-led mental health services to a traditional mental health service
Briscoe et al (2005)	Being There: A Peer Support Service for Older Adults with Mental Illness	Older adults and peer support
Rawlinson et al (2005)	A Review of Peer Support for Suicide Bereavement as a Postvention Alternative	Suicide bereavement and peer Support
Woodhouse et al (2006)	Mental Health Delivery Plan. Development of peer specialist roles: a literature scoping exercise	Existing models of accredited training. Individual benefits for recipients of peer support/service benefits and barriers to peer support
Orwin (2008)	Thematic Review of Peer Support	Models of peer support. Common aspects of peer support

Considering the background information and previous systematic reviews, this review examines the literature describing the perspective of trained formal PSW who are or have been employed to provide peer support to individuals within a mental health setting. The rationale for setting these parameters derives from the current field of peer support research which highlights the lack of synthesised research that focuses on PSW perspectives. Although PSW is being reported to be valued by services, very little is currently known about why and how individuals are attracted to the role of PSW and their experiences once in post. This makes it difficult for the government to plan and implement their vision of incorporating service users into mental health services and to develop effective recruitment and retention strategies. Secondly, the limited exploration of PSW experiences makes it

difficult to establish whether theory is being incorporated into practice and how future research can be directed.

1.5 The research questions:

- What is the available literature on formal paid PSW who have undergone training to provide one-to-one support for individuals within the mental health setting, from the perspective of the PSW?
- What do PSWs report about their experiences of being a PSW?
- What are the potential threats to methodological validity within the studies reviewed?
- What gaps exist in the research literature that could inform the policy literature about PSW?

Method

2.1. *Search strategy*

Papers for inclusion were identified by searching the following electronic databases: Cumulative Index to Nursing & Allied Health Literature (CINAHL) Ovid Medline; PsychINFO; Embase and The Cochrane Library. The search was limited to papers published between January 1990 and August 2010. The rationale for implementing this restriction is that national and international formal peer support in a mental health setting commenced in the 1990s (Carlson et al., 2001). The searches were limited to English. They were organised around five themes, covering the topics of: peer; support workers (also searched providers, specialists, counsellors, recovery support specialists); training, work or employed; mental health or mental illness and adult. The five themes were searched and exhausted separately using various combinations of relevant search terms, before being combined together (appendix A provides an example of the MEDLINE search strategy).

Foreseeing that electronic searches may omit some articles, references of retrieved papers were examined and key informants and experts in the field of formal peer support were contacted to help identify further published or unpublished material (see appendix B). Grey literature was searched in order to reduce publication bias. The database for Grey Literature in Europe (SIGLE) was used.

2.2. *Paper inclusion criteria*

Initially the criteria for including and excluding citations were kept deliberately broad, to avoid the risk of excluding papers reflecting the wide range of peer support. However, the initial selection criteria yielded a large number of references. It was not viable to address the breadth of research across different sectors of peer support and to maintain a liberal screening. In order to produce a smaller and more

focused dataset for review and analysis, boundaries were established through the inclusion and exclusion criteria to enable a more homogenous sample of selected studies.

Papers were included if they: i) appraised a formal peer support program for adult PSW to provide one-to-one support to individuals in a mental health setting; ii) focused on individuals as paid employed PSW for at least part of the study; iii) considered the perspective of a PSW. Papers were excluded if: i) participants of the study were trained to be volunteer PSW; ii) if the support was outside the mental health setting.

2.3. *Paper selection*

Following electronic searches, 336 titles and abstracts were screened and 57 potential relevant articles retrieved. Relevant reference lists were hand searched and provided a further 18 articles for additional analysis. Consultation with key informants of the field presented another 10 articles for further screening. The inclusion and exclusion criteria were then applied. This identified 6 published articles from the following journals: *Work: A Journal of Prevention, Assessment and Rehabilitation*, *Behavioural Health Services and research*, *Psychiatric Rehabilitation Journal*, *International Journal of Psychosocial Rehabilitation*, *International Journal of Mental Health Nursing*. A further unpublished article was identified from a reference list.

2.4. *Data extraction and synthesis*

The majority of the papers selected used different methodologies and incorporated diverse aims, although they largely concentrated on service evaluation. Therefore, an approach had to be implemented to integrate a variety of paper types. There is no single agreed framework for synthesizing mixed methods within a systematic

review (Mays et al., 2005). Some researchers argue it is not feasible to develop a single, operational scoring system to encapsulate the central tenets of both qualitative and quantitative research (Kmet et al., 2004). One explanation for this, suggests that the critique is essentially from a 'relativist' position arguing research offers multiple 'truths' or realities. Subscribing to this standpoint would not allow for replication or transferability and synthesis would be compromised by integrating different methods, theory and knowledge (Mays et al., 2005). In contrast to this perspective 'subtle realism' (Hammersley, 1992) advocates multiple explanations of phenomena forming a core basis, underlying reality or truth. From this positioning, synthesis is accepted as promoting a greater understanding and integrating mixed methods acceptable (Mays et al., 2005). This review adopted this approach and amalgamated mixed methods while being mindful that objections to this approach exist.

To assist the synthesis of data, an assessment tool to aid a criterion for rating papers has been implemented. The Health Care Practice Research & Development Unit (HCPREDU, 2005) has developed an assessment tool to assist in the critical appraisal of research papers incorporating mixed design studies. Structured approaches do not automatically generate less bias in judgement when selecting papers and utility of the various appraisal tools are either unmeasured or quite variable (Dixon-Woods et al., 2007; Lohr & Carey, 2009). However, systematically working through a paper using structured questions monitors decisions the reviewer makes; reducing bias and enhancing reliability

To enhance flexible reporting, Jones (2004) advocates, not a checklist of criteria, but rather, starting points for reflecting on qualitative studies and their usefulness (see appendix C). The benefit of adopting such a technique is that it enables a narrative inductive informative method when reviewing qualitative research.

Accordingly, in addition to using the HCPRDU evaluative tool to appraise the studies selected, the review has incorporated Jones' (2004) guidelines to structure qualitative discussion. It is felt that this approach captures the essence of the usefulness of both approaches.

Results and analysis

Table 2 is an account of data extracted from the seven studies and provides a method of assisting in the critical appraisal of both qualitative and quantitative data collection and analysis. The table and results have been divided into six sub-sections.

Table 2 Evaluation Tool for Mixed Method Studies (Adapted using the Salford HCPRDU, 2003)

Key Questions	Studies								
(1) STUDY OVERVIEW	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7		
0. Author, year, title, country	Moll, Holmes, Geronimo & Shernan (2008) <i>Work transitions for peer support providers in traditional mental health programs: Unique challenges and opportunities</i> CANADA	Gerry, Berry & Hayward (in press) <i>"I have got more of a hope for services as a whole now than I had before": An evaluation of a peer support specialist training programme</i> UK	Richard, Jongbloed & MacFarlane (2009) <i>Integration of peer support workers into community mental health teams</i> CANADA	Hutchinson et al (2006) <i>The personal and vocational impact of training and employing people with psychiatric disabilities as providers</i> USA	Salzer, Katz, Kidwell, Federici & Ward-Coasante (2009) <i>Pennsylvania certified peer specialist initiative: Training, employment and work satisfaction outcomes</i> USA	Meeran, Bergen, Coveney & Thornton (2002) <i>Development and evaluation of a training program in peer support for former consumers</i> AUSTRALIA	Mowbray, Moxley & Collins (1998) <i>Consumers as mental health providers: First-person accounts of benefits & limitations</i> USA		
1. What are the aims of the study?	Examine the issues and challenges associated with integrating peer support providers (PSP) into traditional mental health settings.	Evaluation of the Peer Support Specialist (PSS) training programme.	Improve understanding of peer support workers (PSSW) experiences of perceived value & the influence of recovery models	Examined a training program & effect on peer provider (PP) in relation to personal & vocational recovery.	Longitudinal study to examine a comprehensive set of outcomes associated with the certified peer specialist (CPS) initiative.	To identify the impact of the training on the psychological well-being of the participants.	Explore the positive & negative consequences of the role of peer support specialist (PSS) – 12 months after employment ended.		
2. What are the key findings of the study?	Key work transitions for PSP, from defining and establishing roles, to negotiating the learning curve, and dealing with the challenges associated with their unique role as both consumer and provider.	PSS's reported the training programme had a positive impact personally. Explored wider issues concerning PSS employment & mental health services.	Themes identified: role & power, institutional organization, access to resources, inter/intrapersonal factors & differences over time.	Findings suggest standardised program was used successfully and participant's recovery & employability were improved.	97% successfully completed the program; 22% increase in knowledge; 82% working one year later. Peer specialists reported work satisfaction, acceptance & good but infrequent supervision.	Exposure to people with acute mental health did not, in this instance impact on the psychological well-being of the participants. Barriers to consumer participation are discussed & recommendations offered.	Benefits outlined employed & feeling safe. Limitations outlined – attitudes & costs to own well-being. Changed sense of self that service provider roles can create.		
3. What are the strengths and weaknesses of the study and theory, policy and practice implications?	Opportunity to explore key work transitions from various mental health settings. Provided only a cross-section of perspectives held by peer provider and manager. Framing of interview questions pre-determined the themes.	Positive outcomes may be attributed to other life variables & not the training. Training based on American theory, policy and practice but implemented within UK Trust.	Detailed methodology for study to be replicated. Used triangulation to develop quality assurance. Offers a number of future research directions & recognises findings are tentative. Acknowledges limited experience of researcher.	Only evaluation to test a structured & formal peer support training program. The study acknowledges the limitation of being non-randomised lacks internal validity & had no control group.	First published study to examine & demonstrate increased knowledge after CPS training. Highlights supervision needs. However, compounding variables not considered & sample primarily rural, white, CPS trainee population.	Mixed methods approach taken to gain detailed understanding of the training on psychological well-being. Methodological problem is not addressed.	Provides insights to post training perspectives. Authors acknowledge the article was based on a limited number of consumers from one geographical area.		

(2) STUDY, SETTING, SAMPLE AND ETHICS		Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7
Study	1. What type of study is this?	Qualitative-Collective case study approach with in-depth interviews.	Qualitative-Evaluation: Focus groups	Qualitative-Evaluation: Semi-structured interviews	Mixed-methods. Administering pre and post measurements and personal narratives.	Quantitative: Evaluative study	Mixed methods- focus group discussions & psychometric measures	Qualitative- semi-structured interviews
	2. What is the intervention?							
	3. Within what geographical and care setting is the study carried out?	Community-based mental health service- Ontario peer development initiative, Canada.	Sussex Partnership NHS Foundation Trust – mental health setting.	Community Mental Health Teams (CMHT) – within different areas of Vancouver city.	Peer Educator Training program (Boston) offered by META Service Inc (now research innovations).	CPS training initiative & evaluation (Pennsylvania) Grant awarded from Medicaid to develop & support a peer specialist initiative.	Tertiary psychiatric setting in Queensland.	Michigan – PSS
	4. What is the rationale for choosing the setting?	Part of a larger mixed methods community project.	Service evaluation.	Service evaluation.	Program/service evaluation	Program/service evaluation	Rationale not provided.	Follow-up.
	5. Is the setting appropriate for examination of the research question?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	6. Is sufficient detail given about the setting?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	7. Over what time period was the study conducted?	Not stated-Data collection conducted over 5 months.	Not stated-Data collection conducted over 9 days.	Not stated	Not explicitly stated – data collection over 5 weeks during the training & 12 mths follow-up	12 months	Not stated	Not stated-Data collection conducted in July 1995.
Context 1: Setting								

(2) STUDY, SETTING, SAMPLE AND ETHICS		Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7
Context II: Sample	1. What was the source population? Inclusion and exclusion criterion?	PSP & managers (community psychosocial rehabilitation service for severe mental illness). Exclusion/inclusion criteria not stated.	17 PSS's Exclusion/inclusion criteria not stated.	PSW's Inclusion- spoke English, completed training, lived experience of mental health & employed within CMHT for at least 1 year.	66 recipients of mental health services participated & were referred to the training program by a variety of sources including case managers.	151 individuals applied for the training across Pennsylvania. County administrators selected on a first come first serve basis among all applicants who indicated either having a high school diploma or GED. 74 accepted.	Participants recruited from the community from a newspaper article. Inclusion- self-identification as a mental health consumer, a stated interest in helping others interpersonally & willingness to develop skills in advocacy & peer support. A desirable criterion was hospitalisation at some point.	PSS previously employed by the Project WINS (Work Incentives and Needs Study). Not explicitly stated but to be included had to be a previous PSS employee by WINS. Purposive sampling
	2. How was the sample selected?	Purposive sampling.	Trainees who completed the training program (total=20).	Purposive sampling.	Yes	Yes	consumer, a stated interest in helping others interpersonally & willingness to develop skills in advocacy & peer support. A desirable criterion was hospitalisation at some point.	One group only
	3. Is the sample appropriate to the aims of the study?	Yes	Purposive sampling	Yes	Yes	Yes	consumer, a stated interest in helping others interpersonally & willingness to develop skills in advocacy & peer support. A desirable criterion was hospitalisation at some point.	Yes
	4. Was more than one group of participants?	Two	Yes	No	Yes	Yes	consumer, a stated interest in helping others interpersonally & willingness to develop skills in advocacy & peer support. A desirable criterion was hospitalisation at some point.	Yes
	5. Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn? What are the key characteristics of the sample?	Yes	No	Yes	All 66 completed 5 weeks (60hrs) training. 65% female, 80% white. 73% on psychiatric medication, 73% living independently.	Yes	consumer, a stated interest in helping others interpersonally & willingness to develop skills in advocacy & peer support. A desirable criterion was hospitalisation at some point.	Yes
	6. What are the key characteristics of the sample?	5/6 of the PSP's completed an 8-10 week training program. All worked part time & had experience with mental health services.	All 17 PSS completed 2 weeks training together. All individuals had lived experience of mental health problems.	All completed training. Had lived experience of mental health. All work within the CMHT and for over 1 year.	All 66 completed 5 weeks (60hrs) training. 65% female, 80% white. 73% on psychiatric medication, 73% living independently.	All completed intensive 2 weeks (75hrs) training 94% predominantly white, 56% female, 57% aged 30-50. 30% college graduates.	All 10 participants completed a 16 week training program. 80% female, 90% unemployed at training. Within 6 mths of the program ending several secured paid employment as PSW	All 11 participants were employed as PSS within project WINS. 1 African American PSS, the remaining white. Varied levels of previous work experience.
Context III: Outcome Measurement	7. What outcome criteria were used in the study?	Nvivo software to organise the interview data & iterative process (thematic analysis?)	Thematic analysis	Phenomenological	Scales used to measure recovery, empowerment & self-concepts. Analyses to examine pre-to-post changes were conducted with paired t-tests for correlated data.	60-item multiple choice knowledge test based on the certified peer specialist training curriculum & a 5-point rating scale questionnaire.	State anxiety, trait anxiety, perceived stress, locus of control, self-esteem.	Iterative process (thematic analysis?)
	8. Whose perspectives are addressed?	6 PSW's & 6 managers.	PSS's	PSW	PP	CP S	Participants Used	PSS
	9. Is there sufficient breadth (e.g. contrast of two or more perspectives) and depth (e.g. insight into a single perspective)?	Yes- detailed description but themes largely pre-determined.	Yes depth- detailed description but themes largely pre-determined.	Yes depth- insight into a single perspective.	Yes	No	P psychometrics – no evidence outlined to support efficacy of combined measures Focus group – superficial depth.	Depth covered with detailed description.

(3) ETHICS		Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7
Ethics	1. Was Ethical Committee approval obtained?	Yes University and ethics review boards.	Not stated	Yes – Behavioural Research Ethics Board (University) & Vancouver Health Research Institute.	Not stated	Not stated	Not stated	Not stated
	2. Was informed consent obtained from participants of the study?	No details given.	Yes	Not stated	Not stated	Trainees informed an evaluation was being carried out (not stated whether optional) & asked to provide permission to be contacted up to 1 yr after program – 97% provided consent.	Not stated	Not stated
	3. How have ethical issues been adequately addressed?	Not stated	Confidentiality outlined.	Not stated	Not stated	Confidentiality outlined.	Not stated	Not stated
(4) GROUP COMPARABILITY								
Comparable Groups	4. If there was more than one group analysed, were the groups comparable before the intervention?	Within same project and some pre-set questions the same but different perspectives i.e. integration of worker in a new role and manager perspective of local service issues.	Three focused groups all PSS's within the same training program.	N/A	N/A	N/A	N/A	N/A
	5. How were important confounding variables controlled?		No confounding variables outlined.					
	6. Was this control adequate to justify the author's conclusions?	N/A						

(6) POLICY AND PRACTICE IMPLICATIONS								
Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7		
<p>1. To what setting are the study findings generalisable? If so, what population are the study's findings generalisable?</p> <p>Study states – these findings contribute to the growing body of knowledge regarding peer support within traditional mental health service delivery. However, within this research design it is not intended for results to be generalisable. Tentative conclusions of contribution should be given.</p> <p>Mostly</p>	<p>Study states that the findings will be useful to any service implementing a similar programme. However, within this research design it is not intended for results to be generalisable. Tentative conclusions of contribution should be given.</p> <p>Mostly</p>	<p>Study states that the present study, combined with previous research, provide initial considerations & a number of directions for future researchers.</p> <p>Yes</p>	<p>'Study suggests that employing PP within the mental health system is a strategy that can promote not only a transformation within the mental health system but, we expect, will also promote positive changes in the individuals trained'</p> <p>No</p>	<p>Tentative finding have been outlined about the success of the training, support the continued expansion of similar initiatives.</p> <p>Yes</p>	<p>Not generalisable. Conclusion states the study highlights the need for training & skills development for former patients wishing to participate in mental health service delivery. Well organised training programs, clearly defined roles, and a code of conduct for consumer support workers will further facilitate this.</p> <p>No – results are not generalisable and tentative conclusions of facilitation should be given.</p>	<p>Not generalisable</p> <p>Yes reasonable conclusions & addresses limitations of the study.</p>		
<p>3. What are the implications for policy and for service practice?</p> <p>Could contribute to the service user involvement & recovery literature but is cultural specific to Canadian, Ontario state or simply the local services used within the study.</p>	<p>Training based on American theory, policy and practice but implemented within UK Trust- acknowledged by researchers. Highlights the national gap between recovery policy & practice & the local service issues needing to be central to training programmes. Emphasises barriers to PSS employment.</p>	<p>Have implications for disability allowance and part time working restrictions – relevant for the British Columbia Government but similar issues may arise for UK working tax allowances.</p>	<p>Training and employment presents certain challenges to the existing design of mental health service delivery- organisational transformation & staff training. Documents being more person-centred.</p>	<p>Future research should examine the policy and organizational factors that may influence the implementation of peer specialist initiatives and factors that may affect employment outcomes, such as transportation issues, especially in rural areas, complications associated with modest wages and transitioning off benefits.</p>	<p>Advocate consumer-driven services. Considering the development of code of conduct for professional boundaries when incorporating P SW into services. Balancing the length of training to incorporate important topics but not be overloaded.</p>	<p>Advocates meaningful consumer roles with mental health provision. Advocates organisational change & cultural shift within the mental health service. Implications about supervision and issues around being employed & social security disability income. Issues around handling transitions into health services.</p>		

Implications

Implications

3.1. Study evaluative overview

The main purpose of the studies selected was to evaluate the peer support programme or training and to have a better understanding of the benefits and barriers presented from the point of view of the provider of peer support.

3.2. Study and context (setting, sample and outcome measurement)

Setting

All the studies were conducted within a mental health setting located in USA (n=3) Canada (n=2) UK (n=1) or Australia (n=1). Four studies were qualitative using semi-structures interviews and focus groups. Two studies were mixed methods using psychometric measures and focus groups. One study was quantitative using a questionnaire. All of the studies incorporated purposive sampling which was appropriate for the study aims.

Sample

All study participants were current or previous PSW. Additionally, study 1 interviewed managers of PSW. All of the participants had described themselves as having personal lived experience of mental ill health, excluding the managers in study 1. All of the PSW participated in formal peer support training. Training ranged from 2 weeks to 16 weeks incorporating between 20 hours and 75 hours. Four studies described their training and three studies commissioned an outside service to facilitate the training. None of the papers indicated whether the intervention was delivered as intended or gave reasoning for the amount of time spent on the training.

Outcome measure

In four of the studies there were no outcome measures (1, 2, 3 & 4). This was appropriate to the analysis implemented. In study 4 standardised tests were used to measure various facets of recovery empowerment and self-esteem (Empowerment Scale; Recovery Attitudes Questionnaire; The Tennessee Self-Concept Scale and

The Personal Vision of Recovery Questionnaire). The rationale for using the specific combination of measures derived from the existing literature encompassing consumer involvement in mental health and recovery. However evidence of its efficacy in relation to reliability and validity were not provided. Challenging this approach, a systematic review identifying questionnaires measuring health-related empowerment found that 90% had limited or no evidence in terms of reliability and validity (Herbert et al., 2009).

Study 4 addressed limitations in relation to the study being non-randomised, lacking a control group and threats to internal validity. Recommendations were offered for future research to employ a more rigorous and controlled study to allow more definite statements about the effectiveness of the study. Due to the lack of generalisability and methodological issues, the authors recognised that conclusions were speculative.

Finally, study 4 additionally used personal narratives. Although examples of personal stories were presented, no rationale, method or analysis of the data was provided. Despite the study employing a mixed method approach, it appears the qualitative aspect has been largely ignored and an attempt to credit itself with quantitative methodology has prevailed.

Study 5 used examinations to test their trainee's knowledge of the training program. Additionally, those who were working as a peer specialist (n=44) answered questions using a 5-point rating scale ranging to address questions about the applicant pool, certification and employment outcomes, and satisfaction. Paired *t*-tests were conducted to examine pre and post-test changes on the knowledge test. Study 5 reported that based on the results of their evaluation it appeared that the Pennsylvania CPS initiative had achieved its primary outcome objectives.

3.3. *Ethics*

Two of the studies obtained ethical approval and the remaining studies did not state whether ethical approval was obtained. The majority of the studies were service evaluations; therefore ethical approval may not have been required. Two of the

studies explicitly stated that consent was obtained and confidentiality was outlined. However, it is unclear in study 5, whether informed consent was obtained or if it was a requirement of the training. The remaining studies did not outline ethical considerations.

3.4. Group comparability

Two of the studies compared more than two groups in their analysis. Controlling for confounding variables was not outlined, therefore it is unclear as to whether any were acknowledged and addressed.

3.5. Qualitative data collection and analysis

Two of the qualitative studies included in this review used semi-structured interviews. In most cases the process of the fieldwork was adequately described. All studies used thematic analysis, apart from study 2 which incorporated a phenomenological approach.

The remainder of section 3.5 provides a narrative review (Mays et al., 2005) around recovery. The rationale for paying particular attention to recovery is that it relates to the background information highlighted in the introduction and part of the “critical ingredients” of peer support (Clay et al., 2005).

Study 1

Recovery and peer support was used in relation to employment as “a key element in service delivery” (p 449). Study 1 outlined that PSW are “able to offer services and supports to others with serious mental illness...” (p.449). Furthermore, peer support was framed in the context of helping PSW with their own recovery, although there was caution attached that being a role-model for others could present with inherent challenges and pressures.

Study 2

Recovery Innovations was commissioned to provide the peer support training. Using a DoH policy (2007), study 2 emphasised in their paper that peer support compliments the current recovery and social inclusion agendas in UK mental health providing user involvement, and opportunities for service users to occupy meaningful roles within the community.

Results from this study indicated that the programme appeared to have a profound impact on trainees' perceptions of recovery. Pre-training conceptions of recovery were fairly negative, representing a "meaningless piece of political propaganda" (p5).

However, the study outlined that the "development of a shared understanding of recovery enabled trainees to critically appraise the perceived lack of recovery-oriented practice taking place within the Trust" (p5). Post-training feelings revealed some disappointment amongst trainees which was often attributed to the trust seeming to "lack commitment to the project" (p7). The study recommended that a cultural shift must occur, with a commitment to recovery-practices being made at every level of the workforce.

Study 3

Recovery was a predominant theme. The methodology incorporated a question around recovery models. The introduction reflected that part of a PSW role was to assist clients in their recovery process. Furthermore, study 3 argued that the visibility of PSW sends out a clear message to key stakeholders within the mental health setting that the mental health system is committed to inclusion and adoption of a recovery-oriented practices. Finally, the study outlined that supportive relationships with peers is viewed as a crucial factor for recovery.

Study 4

In this study, a number of the key authors were attached to the recovery centre and META services but the paper did not address whether this provided a conflict of interest. The key objective was to assess how the training program affected personal recovery, using measures and attitudes. The paper did not contextualise recovery or explain its meaning, though recovery and employment were associated together. The introduction outlined that “assisting people to become peer providers can have a profound effect upon the person and their personal process of recovery” (p.206).

Study 5

The study outlined that the central philosophy of the training programme was unique and personal recovery, enabling change in values and attitudes, bringing meaning and purpose in one’s life (Anthony, 1983). The study explained that the training involved a module covering recovery but did not report on the details including whether the principles advocated by Anthony (1983) were featured. Study 5 also linked employment as a path to recovery and supporting other people’s recovery.

Study 6 and 7

The term recovery was not used in study 6 and 7.

In summary, the majority of the studies see recovery as central to peer support, both for recipients and providers. Furthermore, most of the studies outline the need for recovery-oriented practices to be incorporated into governmental policy. Some went as far as calling for a cultural shift in current workforce practices.

3.6. Implications, policy and practice

Due to the nature of the research design none of the studies are generalisable. The intentions of the majority of the studies were to offer tentative conclusions. Nevertheless, the wording expressed in some of the conclusions went beyond

reasonable justifications given the conduct of the study. For example, after conducting research with 10 participants, study 6 concludes that their research;

“...highlights *the need* for training and skill development for former patients wishing to participate in mental health service delivery. Well organized training programs, clearly defined job roles, and a code of conduct for former support workers *will* facilitate the introduction of consumer participation [italics added].” (Meehan et al., 2002, p38)

Building upon existing theory, policy and practice was a key aim for all the studies included and to contribute to the growing body of knowledge regarding peer support within traditional mental health service delivery. It is important to acknowledge that the majority of the studies included were outside the UK and although the studies could contribute to the service user involvement and recovery literature, they are cultural specific. Furthermore, training is largely based on American theory, policy and practice. Any recommendations are therefore subject to interpretation within that locality.

Nevertheless, the recommendations could offer a starting point for formal peer support training in the UK. As previously outlined, the government’s vision is to employ service users within the mental health care (DoH, 2001).

Discussion and conclusion

The aim of the review was to systematically examine the literature evaluating projects which have employed and trained PSW in a mental health setting and to review what PSW report about their experiences. Additionally, a methodological analysis of the studies was conducted. Peer support programmes are embedded in particular policy (notably recovery orientated) and have service implications; therefore a final aim was to consider mental health policy and research implications. However, the majority of the studies were outside of the UK and subsequently the peer support programs were implemented under different policies and practices.

Nevertheless, current UK peer support programs are based on international projects and therefore the selected paper offer some relevance. Although peer support services are becoming more established, relatively few papers were found.

Evidence suggests that individual services often struggle to implement the recovery approach in practice (Anthony, 2000; Chinman et al., 2006). Although the majority of the studies outlined recovery-orientated themes, few were grounded in theory. However, insights were offered as to how they were incorporated into the peer support projects and what benefits and barriers existed. This offers some guidance for future services implementing a peer support project.

Perspective of the PSW

Research on peer programmes has helped to identify the theoretical and practical components that account for their appeal and viability (Briscoe et al., 2005). Incorporated into this has been the reduction of isolation, validation of experiences, increased feelings of acceptance, normalizing the experiences, and the opportunity to re-frame the experience (Campbell & Leaver, 2003; Kennedy & Humphreys, 1994).

The use of interviews within the majority of the studies reviewed in this paper has enabled a forum for the participants to explicate their experiences. Most of the participants identified peer support as invaluable, offering an alternative to traditional mental health settings.

Methodological analysis

While service evaluation and satisfaction data have their value, the effectiveness of peer support programs could be further assessed by more rigorous reporting. The

mental health care system can only be accurately informed of the effectiveness of peer support interventions if programs are published in detail and evaluated appropriately (Macvean et al., 2007). Well-designed Randomised Control Trials (RCT) that include clear baseline measures assessing relevant outcomes and using validated instruments could support the knowledge and decision support approach. In addition, studies with sample sizes large enough to offer sufficient statistical power could help determine the effectiveness of the program.

Qualitative research can contribute to policy, theory and evaluation of services. Many of the papers included in this review, could have been more explicit and clearer in articulating their research design and analysis in order for the reader to accurately interpret the findings. Further evidence of quality assurance could support the validity of the findings. For example a criteria for following some flexible principles has been offered by Yardley (2000), as a guide to the quality of a qualitative study (sensitivity to context; commitment and rigour; transparency and coherence; impact and importance). Additionally, only one researcher in the papers selected, outlined their epistemological position and integrated reflexivity into the study. This procedure allows for greater transparency in how the researcher is subjectively embedded within the research and what methods they have taken to address any biases. Adopting this approach could further support the quality of qualitative papers. Finally, the studies mainly incorporated a thematic approach. Other approaches such as phenomenological interpretative analysis or grounded theory could potentially move the analysis beyond description and develop understanding of theory and practice when considering peer support programs.

Recovery, policy and practice

Research delineating the role of peer support in recovery from mental illness is limited. Furthermore, Davidson et al (1999) argues that the lack of methodological thoroughness diverts attention from the efficacy of much of the available research (Davidson et al., 1999). Similar findings have occurred in this review. A final

problem is the concept of recovery in the context of mental illness and the arbitrary nature of both terms. Recovery and mental illness are complicated further by their interwoven relationship and the reality that the pattern of recovery from mental illness rarely follows a linear route (Briscoe et al., 2005). Consequently, attempts to neatly unfold the association between recovery and mental illness are problematic. Nevertheless, as outlined in the introduction, peer support programmes have gained significant attention as a valuable component of mental health recovery-orientated service delivery (Moll et al., 2009) and have become a central focus of mental health policy, guidelines and framework (DoH, 2009). Recovery was a central theme throughout most of the studies reviewed in this paper. However, implicit assumptions about recovery were often made within the studies without definition or reference to its' subjective nature. Future studies would benefit from exploring recovery from the perspective of the PSW, especially given the theoretical problems associated with the concept of recovery.

There are many initiatives focusing on mental health and employment which can make it difficult for policy-makers, managers and practitioners to have a clear picture of the theoretical underpinnings, the strategy and what the actual benefits might be (Johnson et al., 2009). The gap between policy and practice has been identified within some of the papers included in this review and how the principles and practices underlying the projects could be important steps towards a more supportive workplace culture. Many of the studies were based on the FACITS "critical ingredients" of peer support which have been reported in previous studies. Although evidence has been provided by the COSP, no other sufficient evidence for the reliability and validity of this measure has been reported. It seems particularly pertinent that the robustness of a measure that underpins theoretical concepts is replicated. Particularly when peer support programs are based on it and the potential impact it could have on policy and service legislation. Future recommendations would be to rigorously appraise the FACIT tool.

Previous systematic reviews have appraised existing UK documents to identify areas and priorities for the future research involving service users and carers (Keating et al., 2006). Similar mapping of existing documents relating to formal peer support services could provide clearer indications of the gap between policy and practice.

2.5. Limitations

Acknowledgement has previously been outlined that this paper did not subscribe to a double-blind peer review. However attempts were made to remain transparent throughout the review and to monitor decisions through checklists with structured approaches.

There are potential problems of multiplicity analysis, particularly when the studies used different methodological approaches. Indeed this review incorporated several guiding principles when extracting and analysing the data. Using more than one evaluative tool may have caused underlying conflicts. However a 'subtle realism' (Hammersley, 1992) position was adopted which permits this and indeed makes clear attempts to address the conflicts.

Non-English sources were not searched which could potentially have been a valuable source of research.

2.6. Conclusion

In conclusion, the focus of this systematic review has been on appraising the available literature on formal paid PSW who have undergone training to provide peer support within the mental health setting. Secondly, it aimed to explore what PSW report about their experiences of being a PSW. Finally, the studies were evaluated to consider potential threats to methodological validity and to establish

gaps that exist in the research literature that could inform the policy literature about PSW. Although the literature on peer support within the mental health setting is relatively recent, research is evolving. Nevertheless, there is a lag between the development of theoretical understanding of peer support in the mental health setting and empirical validation of the approach.

Recommendations in this review reflect the strengthening of the growing body of knowledge regarding peer support within mental health service delivery and further studies would benefit from incorporating more robust methodologies. Nonetheless, the majority of the papers selected for the review were service evaluations. Therefore, recognition has also been afforded to those papers not necessarily attaining acceptable levels of research standard but providing valuable insights into the perspective of PSW and offering potentially useful recommendations for future programmes.

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Journal paper

“Going through the transition from being an end user to sort of the provider”: Making sense of becoming a peer support worker using Interpretative Phenomenological Analysis

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Introduction

Employment of PSWs is considered a valuable component of recovery-orientated mental health service delivery (Moll et al., 2009). Peer Support (PS) is regarded as an important factor in recovery for both providers and recipients (Repper & Carter, 2010). Nonetheless, there is limited in-depth qualitative research exploring this innovation and the assumptions around recovery, making PS appear aspirational rather than grounded in empirical research.

PS aims to provide psychosocial, emotional and practical support. Individuals with similar life experiences relate to and offer authentic empathy and validation to PS recipients using “respect, shared responsibility, and mutual agreement of what is helpful” (Mead et al., 2001, p.135). However, no single, commonly accepted definition of PS exists (Repper & Carter, 2010). Although useful for an evolving role, problems arise when assessing the effectiveness of PS and identifying which, if any, of the PS principles are effective in promoting recovery among those in receipt of PS. NHS Trusts are beginning to employ PSWs in line with policy aiming to transform the workforce and work in partnership with PS (DoH, 2010). However, there remains limited understanding of the implications of this for individuals enacting the PSW role.

Recent research both supports (Repper & Carter, 2010) and questions the effectiveness of PS (Bracke et al., 2008). Studies suggest PS facilitates recovery, reduces stigma, fosters social approval, supports professional development, provides mutual support and offers financial rewards (Mowbray et al., 1998; Ochocka et al., 2006). Equally, barriers to implementation have been identified, including staff attitudes towards recovery, role conflict and confusion, lack of supporting policies, poorly defined jobs and lack of support (Gates & Akabas, 2007). PSWs have outlined negative experiences relating to job stress and blurred boundary issues (Mowbray et al., 1998). Although these exploratory studies provide some insight into the experiences of PSWs enacting the role, there is an absence of research exploring the transitional experience.

The PS literature frequently compartmentalises differing identities (e.g. professional, service-user, friend) associated with PSWs and some advocate for PS to be distinct from traditional mental health services (Clay, 2005), contrary to interprofessional working. Presently, there is limited understanding of whether PSWs synthesise these roles and how they relate to services. This seems particularly important given that wider research exploring transitions within the NHS suggests that problems may develop from the separateness of disciplines (Thomas et al., 2008) or attempting to manage dual roles (Andrew & Wilkie, 2007). Furthermore, dual relationships that may exist with teams that have previously or currently provide PSWs with mental health services, has been neglected (Repper & Carter, 2010).

Transitions recur across an individual's lifetime with varying degrees of frequency, considered to be a process rather than a single event (Williams, 1999). Transitions can create uncertainties, anxiety or distress, even if viewed positively (Petch, 2009). Coping resources such as commitment, social networks and seeing the transition as a challenge rather than threat can help develop psychological well-being (Furnham & Bochner, 1986). Sluss and Ashforth (2007) offer a framework of understanding the role transition into an organisation and the interaction of identity on a personal, interpersonal and collective level. The propositions within the model remain largely speculative and difficult to test and it is acknowledged that the framework could be criticised for oversimplifying relational identification, whilst ignoring factors such as social and cultural experiences. However, the framework's consideration of identity on a personal, interpersonal and collective level could have implications for employed PSWs entering the NHS and how they manage a number of roles.

In summary, there is limited research exploring PSWs' experiences of transitioning from their own lived experiences of mental health problems to supporting others with mental health problems. The present study is the first to adopt a phenomenological viewpoint aiming to explore how individuals made sense of their transition.

Method

Consistent with the research aims, the qualitative approach IPA was chosen because it was theoretically rooted in phenomenology, hermeneutics and idiography and complemented the critical realist position of the first author who was solely responsible for the data collection and analysis.

Participants

Participants were purposively selected from a PS service operating within an adult mental health service in England. All ten PSWs employed in the service were invited to participate and seven did so. Participant details are presented in Table 1. The sample was homogeneous in that participants had all experienced a transition into being employed as PSWs within the same service. There was variation in the sample: one participant had never received mental health services despite experiencing mental health problems; two were currently receiving mental health services whilst within their PSW role and four were no longer in receipt of services.

Table 3

Participant information

Gender	Male	2
	Female	5
Age (years)	Range	22 – 59
Ethnic Origin*	White British	3
	White Irish	1
	Other White Background	1
	White & Black African	1
Clinical Diagnosis*	Psychosis; Bipolar; Stress related illness; Depression and anxiety; Anorexia Nervosa; None	
Service Received*	Early Intervention; Drug and alcohol; Recovery; Crisis; Community Mental health Team; Inpatient; Eating Disorders; Personal mentors; GP only; None	
Contact with MH Services (years)	Range	0 – 24

*NB some participants did not wish to disclose certain demographic details.

Procedure

Ethical approval was obtained from the NHS research ethics committee and Lincoln University. Participants were recruited via the PS Project Coordinator who provided all PSWs with information packs about the study. Interested persons contacted the first author to arrange to participate.

Following IPA methodology (Smith et al., 2009), interviews were conducted and digitally audio-recorded. A semi-structured interview schedule was used with non-directive, open-ended questions, and prompts to enable participants to reflect on their experiences of becoming a PSW, whilst allowing for tangents to develop (Smith et al., 2009).

Interviews were conducted within PSW workplaces and lasted between 46 minutes and two hours. All participants accepted a £10 voucher for participation in line with Reward and Recognition (DoH, 2006). Permission was obtained to use verbatim quotations in the final report. Pseudonyms are used throughout and identifiable data removed.

Analysis

Interviews were transcribed verbatim then analysed using the IPA principles and processes outlined by Smith et al. (2009). Each transcript was analysed in turn utilising an idiographic approach. This began with particular examples and slowly worked towards a more general categorisation, enabling consideration of convergence and divergence within the sample.

With the themes, psychological knowledge was incorporated, aiming to capture the meaning of the data at a higher level of abstraction. Caution was taken to not lose the connection between interpretations and the participant's own words. The next stage consisted of further reducing the data by clustering themes together according to conceptual similarities and creating superordinate themes. Repeated patterns developing in the subsequent transcripts were identified whilst allowing additional topics to surface (Smith & Osborn, 2003). Extracts from interviews were used to support each theme and ensure that an audit trail could be traced back to the raw data (Smith & Osborn, 2008).

Quality Assurance

Both qualitative (Yardley, 2000) and IPA specific (Smith, 2011) guidelines were followed to ensure rigour and quality control in the research.

IPA Critique

IPA incorporates multiple levels of analysis (descriptive, linguistic, conceptual interpretations), sometimes at the expense of extensive analysis (Smith, 2011). Although, IPA offers practical and accessible guidelines it has been criticised for being restrictive (Braun & Clarke, 2006) although Smith et al. (2009) reason that researchers should be adaptable with the framework. This study considered the guidelines as flexible and endeavoured to explore both depth and breadth within the analysis.

Results

Three superordinate themes were derived from the analysis: (i) *Fluctuating identities* (ii) *PSW role* and (iii) *Organisational culture*. They were interpreted as interdependent with interrelating subordinate themes. Although the themes were not arranged in chronological order, participants often made sense of their transitional experience by drawing on the past (entering the role and expectations), present (during the role) or future (aspirations and exiting the role). The underlying thematic structure of the results is displayed in Table 4.

Table 4

Composition structure of IPA themes

Superordinate themes	Subordinate themes
1. Fluctuating Identities	1.1. Changing Social Self
	1.2. Recovery, growth and acceptance
	1.3. Difficulties managing multiple identities
2. PSW Role	2.1. Role Clarity
	2.2. Role vagueness and difficulties
	2.3. Boundaries and disclosures
3. Organisational Culture	3.1. Changing the system
	3.2. Attitudinal support and barriers

The quotes presented were selected because they were felt to epitomise the most prevailing expressions of that theme.

Fluctuating identities

This superordinate theme captures participants' multiple and overlapping identities, which appeared to ease the transition into the role but difficulties in assimilating identities were detailed in all accounts. Three subordinate themes were identified:

1.Changing social self

This reflects all participants' expression of group affiliation in relation to self and others. Participants detailed how the role enactment had created identity transformations. Hannah explained: *'I'm kind of shedding my service-user shell, even though I'm still a service user'*. For Hannah change appeared tentative but perhaps highlighted her affiliation to both a service-user identity and the natural process (as suggested by "shedding") of no longer needing the service user identity. Five participants expressed more distinct changes and detailed additional identities in relation to becoming a 'role model'. Simon self-identified as becoming *'a role-model and inspiration for people'*, departing from his previous postulations of being seen as *'worthless'*, suggesting the role provided a sense of purpose and a different way of being viewed by others.

Additionally, participants reported a greater sense of belonging following their transition into the service. Scarlet expressed this when describing her experience of entering the workplace and *'...the team saying we'd love you-, come and work for us. We'd love to have peer support and we'd love to have you'*. Scarlet retelling the story in the interview reiterates her position of group belonging and acceptance and possibly her sense of positive self-image.

2.Recovery, growth and acceptance

Overall participants reported an ongoing sense of personal growth during the transition into the role. This was characterised by reconnecting, recovering and taking control, which was seen to contribute to their recovery from mental health difficulties. Peter captured much of this:

I've re-found, restructured, re-shaped parts of me and my identity (...) to re-affirm the guy that I was.

Prefixing his words with *re* suggests Peter is now in a position to recover aspects of a possible lost self. Five participants reported personal growth further in relation to developing a more open sense of self and being liberated from an almost hidden identity. Lucy explained:

It's [PS] taken the stigma away and also having a job where you don't have to hide it [mental health difficulties] (..) people automatically know that you have had problems, it has been ... emancipating.

For Lucy the inclusion of the word 'peer' in the job title to communicate lived experience of mental health problems provided her with the experience of feeling accepted and perhaps has enabled her to feel less stigmatised by actively naming mental health problems.

3. Difficulties managing multiple identities

In contrast to the relative fluidity gleaned from multiple identities, all participants reported a continuing sense of dissonance, either explicitly expressed within the interviews or interpreted from conflicts within transcripts. Internal dilemmas arose when considering whether the PSW role provided the identity of a professional, a patient or a friend. External conflict occurred when the service, staff or recipients placed a non-preferred identity on the PSWs. This is encapsulated when Hannah initially explained she identified with the role being '*more like a friendship role, a professional-friendship role*' but then detailed how recipients had attempted to contact her on social networking sites or had sought friendship intimacy (e.g. hugging). In these instances, Hannah resorted to a professional identity and boundaries, resolving that '*it creates a respect between the two of you...and gives you a bit of confidence and authority I suppose*'. Although there is subjective interpretation, the concept of friendship is generally an interpersonal relationship with positive reciprocity, a supposition often accredited with PS. The authors are left wondering how this can be negotiated when subsuming "authority" and power through professional identity.

Five participants detailed negative experiences within their PSW identity. Lucy described the immovable nature of '*always going to be in that sick role*'. Peter further conveyed his distaste when being stigmatised by colleagues:

I still don't like part of that identity [having lived experience of mental health problems] for peer support...when I first went in the team, you could see people looking, thinking... the medical model was there, it was like ok, "you're here Peter, you look ok, but what's wrong with you [laughs]...I don't wanna be mad to have the job.

Rather than being integrated into the team and Peter's desires to be '*one of the boys*', he was left feeling different and possibly feeling tokenistic for being identified as 'mad' in order to have the job.

Similar to other participant transcripts, the above accounts highlight the juxtaposition of the PSW identity with it being both emancipating and constraining. Both Lucy and Peter felt they were employed because they were in the 'sick' or 'mad' role but were liberated by the initial PSW experience. However, this was perhaps a temporary state prior to a realisation that the PSW identity continues to restrict their freedom because they endure the labelling experience of being a 'patient' or 'mad'. This could hinder personal recovery from mental health difficulties and perhaps even negatively impact on an individual's wellbeing. This highlights complexities associated with an individual's sense of self when making this transition, being both a flexible navigation and appearing to be fraught with situations creating access or denial to a progressing transition. One solution participants identified was to attempt to change the mental health system, which is discussed in the final superordinate theme.

PSW role

This superordinate theme represented what the role of PS meant to participants and how it was enacted. This was broadly encapsulated under two subordinate themes:

1.Role clarity

For all participants, making sense of the PSW role was facilitated largely by current philosophical underpinnings within the PS literature ('person-centred approach', 'inspiring hope and recovery', 'mutual support' and 'promoting autonomy') and was

accessed through the job description and induction training. These factors added clarity and facilitated a palpable concept of PS. Furthermore, participants considered what would have been helpful for them in the past. Lucy wished *'there'd been somebody like that for me and my own recovery'*. Peter described PS in a way that translated the theoretical underpinnings into his practice:

We want to stand with you [recipient of peer support] and for you, we want to share your world and interpret and accept, to tell your story and give you back your dignity. And not put you in a dependant role.

Peter's quote captures the positioning that participants tended to adopt whilst in the PS role. Their understanding of the role appeared twofold. Firstly it was to help construe meaning for the recipients and promote self-worth and autonomy. Secondly it was to interpret and communicate this with the outside world, perhaps other professionals. This was considered possible because of their shared experiences of mental health problems. Again, problems exist with the conflicting position of identifying with the mental health experience, as above, but simultaneously rejecting the identity and not wanting to be viewed as 'mad' to have the post.

2.Role vagueness and difficulties

Six participants detailed the changeable and ambiguous nature of the role, although this equally offered role flexibility. Hannah explained:

We're [PSWs] still learning...it is a completely new thing that we're deciding how it should be, what it should look like, where it should go...

In contrast, the dynamics of the job led to all participants questioning the value of the role. It was extrapolated that these difficulties sometimes interfered with the participants' recovery and placed strain on newly formed roles:

Pauline: ... you're very much expected to (...) be able to talk about your experiences which I have to an extent but it's not anything that has been good for me.

Nadia: ... I have to make a conscious effort to actually give that short explanation to people. I had a bit of meltdown, got ill, am better now and

this is my work...[she has considered] entertaining the idea of making out my job isn't peer support. I could leave the peer bit out and say "oh I work for the community mental health team as a support worker.

Again both accounts capture the complexities associated with the role enactment and a juxtaposition of conflicting positions. When Pauline fulfils the 'peer' aspect of the job and shares her lived experience of mental health difficulties, she risks her own recovery. For Nadia the 'peer' aspect of her job creates a polarisation of being both open and wanting to be hidden. These discrepancies have perhaps prevented participants from fully engaging in their role and created complications when making sense of their transitioning experience. Sharing experiences and equality are fundamental elements to the role, yet Nadia and Pauline highlight how they have struggled to put this into practice.

Organisational Culture

This superordinate theme considered participants' experiences of becoming a PSW within the NHS, how participants made sense of their role within the system and what affected the transition. Two subordinate themes were identified:

1.Changing the system

Working to change the system added clarity and meaning to the role, which in turn enabled participants to experience a more well-defined transitional experience and to better manage the fluctuating identities because of a clearer focus for the future.

All participants discussed the need for a paradigm shift; challenging the medical model and advocating a person-centred approach. This was illustrated when Peter summarised the existence of PS in promoting and empowering the individual and rejecting the traditional medical approach taken by some professionals:

...someone not saying medical model, you're ill, you're sick, you have hallucinations, you have delusions, deficit model – you can't, you can't, you can't, you must, you must, you must. This is where the professional

lenses, can for many people be, somewhat disabling and disable-less. It means you are your own person, you can take responsibility, you can plan, you can do things and meaningful things.

Four participants recognised the need for change in the existing system. Scarlet expressed with upset how *'damaging services can be'*, comparing services to a *'swamp'*. Scarlet's simile evokes a sense of hopelessness and perhaps the powerlessness she felt when personally involved with services. Again, this resonates with the previous interpretation that whilst enacting the role, participants consider their own recovery and an awareness of the barriers they previously experienced. Scarlet concluded *'you tread and get so far and then the whole thing just absolutely comes and swallows you up'*. Maintaining awareness of the potentially detrimental effects of existing mental health services through the transition into the PSW role appeared to be an important aspect of being a PSW.

Perhaps in retaliation to this powerlessness, five participants identified with being agents of change and wanting to reduce the disparity between patient and provider. Lucy summarised:

I think to have that person [PSW] that is bridging the gap between; they work in the NHS but they also had similar problems, then it's less intimidating. It makes the service less scary.

However, as previously outlined, Hannah explained the role provided 'authority' and Nadia considered removing the word 'peer'. This highlights the problems of hoping PSWs can effortlessly mediate and bridge the gap between patients and providers because of their dual relationships.

2.Supporting attitudes and barriers

Six participants spoke about acceptance and being valued when considering support from others. Peter simply explained *'they [staff] accept who I am, why I am, what I do'*. However, similar to previous accounts outlined, there is an element of incongruence between Peter's sense-making. Rather than feeling accepted, Peter had earlier alluded to feeling like an outsider. Perhaps this reflects change over time or that there is an

intricate interplay of identifying with others, represented on an interpersonal-intergroup continuum rather than a polarisation of acceptance and non-acceptance. Congruently, Pauline detailed a negative experience throughout her transition, but valued the amount of support received within the PS service: *'My experience has not been a particularly positive one all the way along. But I have had a lot of support which is maybe why I've probably been able to continue.'*

Despite the support available, six participants outlined problems around staff attitudes and limited understanding. Simon expressed his dismay at staff when initially going into his team: *'The patients were more (..) understanding about who we were and what we were there for and what we were doing than the actual members of staff'*. Conceivably, Simon entered the role expecting staff to be knowledgeable and clear about the PS service but took more encouragement from PS recipients. This experience seems to intensify the separation further between patient and provider and again creates problems for assimilating a PS identity that incorporates elements of professional, patient and friend.

Finally, all participants described the presence of stigma obstructing empowerment. During the interview, Peter candidly reflected that *'I suppose I'm internalising stigma aren't I?'* Furthermore, Nadia considered the hidden experiences of mental health difficulties among NHS staff:

...what people working in a mental health service would willingly disclose they have mental health problems? ...even though they're quite open about us ... there are still people who fear there'd be repercussions or kind of watched to see if they were going a bit odd.

Nadia highlights the PS service paradox. Participants have emphasised the empowering aspect of the PS service in relation to raising the profile of mental health difficulties through the job title. Yet the service is placed within a wider system whereby the fear of being stigmatised prevents others from being open. Thus the service remains separate from other NHS services and the gap continues to exist.

Discussion

The study aimed to explore how seven PSWs made sense of their transitional experience. The results demonstrated that participants considered the complex, individualistic and changeable disposition of the transition. Furthermore, participants contemplated what constrained the enactment of the new role and what facilitated it. These experiences were principally captured under the three superordinate themes: (i) *Fluctuating identities* (ii) *PSW role* and (iii) *Organisational culture*.

Sluss and Ashforth's (2007) model presents a useful framework for understanding the participants' experiences and how they defined and located themselves within the NHS. Sluss and Ashforth's (2007) identity theory considers multi-identities within an organisational context, rather than a single-level analysis. Additionally the framework considers an individual's changeable 'social world view' relative to relational identity. This concept seemed to resonate with the participants' descriptions of their experiences. Despite aforementioned shortcomings of the model, its basic elements are useful in beginning to develop more integrative theorising and addressing both convergence and divergence within workplace identifications.

The personal level incorporates individual traits, abilities and goals. The findings suggest that at this level, aspects of the transition identified in the *changing social self* and *recovery, growth and acceptance* subordinate themes enabled participants to perform the role. Furthermore, *role clarity* provided participants with the knowledge of their individual traits. What impeded participants to enact their role was the impact on own wellbeing. Experiencing stress whilst in the PSW role has been previously discussed (Chinman et al., 2006). McLean et al. (2009) reported that some PSWs within their research became unwell during the pilot scheme but were able to 'make constructive use of their experiences of recovery' (p.1). In contrast, this research highlighted that for some participants the role was detrimental on self-recovery, despite support being available and sought. Subsequently, this then impacted not only on their individual identity but the mutually dependent interpersonal and collective identity.

Within the interpersonal level, participants experienced many role-relationships (e.g. PSW-PSW, PSW-Recipients, PSW-staff). Sluss and Ashforth (2007) argue that individuals are interdependent on the nature of the role-relationship interactions and the potential for personal intimacy derived from these. Participants reported difficulties when managing the differing interpersonal relationships. Being a *role-model*, *not hiding self* and *acceptance* provided participants with clarity and meaning of the role in relation to others. This supported their integration into the job and is comparable to previous research which emphasises that fitting in or being accepted in the workplace can be a key transition point (Moll et al., 2009). However, what complicated the role-relationships were complexities around *role vagueness* and *role difficulties* which have previously been reported to be a challenge (Mowbray et al., 1998) and arguably impact on the interpersonal, personal and collective identity. Repper and Carter (2010) advocate the implementation of specific measures to define, maintain and value the distinctive PS role. Davidson et al. (2006) attempted a workable definition of the PSW role, based around possible functions, but this has been interpreted in different ways and considerable variation exists (Moll et al., 2009). In contrast, Sluss and Ashforth (2007) reason that no two individuals are identical and therefore no two role enactments are identical. This was reflected in the current findings that participants understood the role in different ways.

At the collective level the focus is on the individual as a member of a group, organisation or social category. Participants experienced group belonging at a number of levels. *Changing the system* further provided participants with an organisational identity and a collective motivation of developing services to represent a more recovery-orientated focus. Previous studies have suggested that PSWs can bridge the 'them and us gap' which invariably exists between service users and the mental health system (McLean et al., 2009). Although influencing the NHS culture through the PSW role has been alluded to in a previous study (McLean et al., 2009), the emphasis placed on *changing the system* in this research is novel to the PS literature.

In contrast, the complexity of multiple identities invariably created difficult experiences for participants. The tensions between the roles of 'peer' and 'professional' have been previously reported (Moll et al., 2009). Some research argues that PSWs are eager to

distance themselves from a professional role and avoid the professionalisation of PS (Repper & Carter, 2010). However, the results suggest that this may be an oversimplification of the PSW experience, disregarding the multiple identities that PSWs manage when enacting their role. At times, these identities were purposely assimilated rather than separated. Wider research suggests that poor transitional management and support, including lack of understanding, can be an inhibiting factor in transitions (Williams, 1999) and is worth considering within the PS literature.

Finally, the findings highlighted the intricacies of stigma, which for participants permeated all levels of identity, impacting on the role enactment. Previous studies reason that PS can actively reduce stigma (Mowbray et al., 1998; Ochocka et al., 2006). Whilst these results partially support these claims, they emphasise how stigma is inherently attached to and perpetuated by the PSW role at both a macro-level and micro-level. Policies (DoH, 2010) aiming to weaken professional boundaries create explicit roles for 'peers', but this reinforces the idea of patients and providers being two separate entities that need to be bridged rather than placing efforts on de-stigmatising this dual relationship that invariably permeates all professional levels within the NHS. Additionally, participants described having non-preferred identities placed upon them. At times, participants found themselves transitioning out of one stigmatised role into another (e.g. 'mad' or 'sick' PSW), which may have negatively impacted on their own wellbeing and identity.

Clinical implications

This study contributes to the UK PS literature. Although further exploration and evaluation is needed future research may be informed by the presented findings. Role transition, relational identity and the social identity literature is not yet a prominent feature of the PS literature. Perhaps this is partly due to the focus of justifying its relevance and value as a mental health recovery-orientated service. The PS ideology argues that the lived experience of mental health problems is the key factor in supporting recovery and reducing stigma (Mowbray et al., 1998). Yet this research highlights that some PSWs were keen not to identify with their lived experience, and some highlighted its stigmatising impact. Without properly addressing the complexity of

the role enactment and the multifaceted identities which both support and impede the transition, the process may be oversimplified and general assumptions offered without properly preparing PSWs, PS recipients, teams and the organisation for the implementation of PS. Subsequently, this could have a detrimental impact on the individual at all three levels of identity, which would then invariably negatively impact on the value of PS generally. Therefore, the study advocates training that is tailored to the individual need, that recognises the uniqueness of the role, enabling understanding to be an ongoing process rather than an immediate awareness. Additionally, flexible support is essential throughout the process and may need to stretch beyond the PSW (e.g. work colleagues). However, services should be cautious not to imply that all PSWs will encounter an enduring transition into the role with multi-layered complexities. Finally, self-narrative identity work could help newly appointed PSWs to articulate and co-construct their identities during the transition; contextualising professional, personal and practice development (see Ibarra & Barbulescu, 2010).

As previously outlined, transitional problems within the NHS may exist with the separateness of disciplines (Thomas et al., 2008). Accordingly, the above recommendations cannot occur in isolation to the organisational context. The long-term success of PS will also be dependent on the workplace providing flexibility for integration of new ways of interprofessional working that operate within less demarcated boundaries than traditionally witnessed within mental health services.

Limitations and future research

A potential limitation is the retrospective nature of the accounts, with possible salience of particular events being skewed by memory. Furthermore, the interviews were conducted at a certain point of the participants' transition into the role. It may have been beneficial to have interviewed participants at various stages. The results captured all participants at the same point in their transition which was a unique opportunity. However, there remains a need for more longitudinal research to better understand the processes underlying the enactment of the PSW role and other transitions such as the exit of the PSW role which will invariably occur. A further potential drawback is the homogeneity of the sample. All participants were PSWs with lived experience of mental

health problems, were employed within the same PS service and for the same period of time. However, there was variation. It could be argued that this affords breadth in addition to an in-depth study and accurately reflects the diversity within the PSW population.

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Extended paper

1.0 Rationale for journal choice

My journal paper was written for submission to the Journal of Mental Health which currently has an impact factor of 0.875 (Reuters 2011). The journal attracts multi-disciplinary international coverage and depicts the most recent research in the MH field. The journal publishes existing examples of good practice and aims to influence policy by publishing developments that dispute traditional ways of working. It is dedicated to publishing first-class, thought-provoking work that will directly influence service provision and clinical practice. My study aimed to inform PS services about the participants' experience of transitioning into providing a service and enacting the PS role. I felt that this journal would reach the intended audience. Although the current journal article was over the recommended 4000 word limit, personal correspondence with the editorial team confirmed that that this was acceptable for a qualitative publication (appendix D).

Extended Paper

The extended paper forms an adjunct to the journal paper. This will expand on information and data that could not be included in my journal paper. The extended paper consists of extended introduction, methodology, results and discussion sections. The decision making and conclusions drawn during the research process reflected my epistemological position and are discussed further in the extended methodology section.

2.0 Extended Introduction

This section provides consideration of previous literature incorporating peer support (PS) and the aims and rationale of the current research. It offers further justification as to why particular psychological processes were considered to be important within this field of research. However, before outlining this, a note on terminology is delineated, a definition of PS deliberated and current policy reinforcing the implementation of peer support workers within the UK is taken into account.

2.1 Note on terminology

Service users

Although describing recipients of Mental Health (MH) services has changed over the years¹ and can offer different connotations, the term 'Service user' appears regularly in policy documents, mission statements and the research literature. The language used in MH trusts and national guidelines is often uncritically offered. Self-identified terms could be more preferable. Simmons et al. (2010) found that the majority of recipients of MH services in Hertfordshire preferred the term patient and client². Although Simmons et al.'s (2010) research is not generalisable, it suggests the need for dialogue about preferred terms. However, aligned with current literature and for the purpose of using a collective term within this thesis, I have used the term service user. Nevertheless, I understand that service user continues to be a disputed term and can be seen as both helpful and unhelpful with the individuals for whom it is used.

Peer support workers

The range of terms used to refer to service users employed by MH services include consumer advocate, consumer representative, consumer worker, consumer consultant, counsellor, advisor, peer support worker, peer support specialist, peer support provider and service user. Such terms and their definitions are the subject of discussion in current literature. For the purpose of this research, I have used the

¹ i.e. service user, patient, client, user, survivor, consumer

² Although this was dependent on the professional Whether consulted by psychiatrists, nurses, social workers or occupational therapists

term 'peer support worker/s' (PSW/s) and have focused on 'intentional' PSWs who have been employed to provide a PS service. When referring to individuals who receive support from PSWs, I have used the term recipients of peer support (RPS).

Recovery

Recovery from MH health difficulties is a comparatively new concept. Attempts have been made to define this notion through national consensus and findings suggest that it is a "journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential" (SAMHSA, 2004, p.16). For the purpose of this research, recovery has been understood to be a highly individual process dependent on the individual's own knowledge and experiences. However, I have understood it to broadly represent coping with mental illness and working towards mental wellbeing, though recognise this definition may be disputed. Recovery-orientated services can be considered to "instil hope that recovery is possible and that mental illness does not have to be lifelong or chronic. They empower consumers to take personal responsibility for their wellness and include consumers in decisions that concern them" (Frost, Heinz & Bach, 2011, p.1). Although different explanations exist, I felt that this particular definition was compatible with the philosophy of PS. For the purpose of this research, I have understood recovery-orientated services to denote the above definition, unless reviewed research offers an alternative meaning.

Lived experience

Finally, current PSWs within this research had to satisfy the essential criteria of 'lived experience'. Lived experience is often used to describe the first-hand accounts of living as a member of a minority or oppressed group. For the population in this research it usually means severe MH difficulties. However, using the word 'lived' has been criticised for being illogical and that all experience is lived as opposed to dead. Again, aligned with the PSWs who participated in this research and their needs to satisfy the personal specification of the job, I have used the term

lived experience but have remained mindful that it can be viewed as a meaningless concept.

2.2 Background and definition of intentional peer support

The employment of PSWs in MH settings is a comparatively new trend, beginning in the 1990s (Carlson et al., 2001). In the last 20 years PS services have developed substantially across the United States, Canada, Australia and New Zealand (Repper & Carter, 2010) and have now spread to the UK (Woodhouse & Vincent, 2006; Ley, 2010). There is a developing movement in MH care towards recruiting individuals with lived experience of MH difficulties as PSWs, in order for them to support RPS with their recovery process (Richard, Jongbloed & MacFarlane, 2009). Employment of PSWs is in contrast to informally provided PS which has a long history, has traditionally taken place outside the MH setting, and has generally operated as self-help groups (Salzer et al., 2010). In other fields (i.e. cancer, addiction, trauma and physical health) the use of intentional PSWs is well established (Davidson et al., 2006). According to Woodhouse and Vincent (2006) there are four main models of intentional PS: user run drop-in, intentional peer workers, training programmes for peer specialists, and peer education. This research has concentrated on intentional PSWs.

‘Peer’ in this context is often used to denote a person who has lived experience of MH difficulties and has invariably used or has used MH services (Ley, 2010). Consequently ‘support’ is provided by peers to individuals who have common shared experiences (Ley, 2010). There is no single, commonly accepted definition of PS. However, an extended description (Mead, 2003, p.1) is often quoted within the PS literature:

‘Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another’s situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are ‘like’ them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to ‘be’ with each other without the constraints of traditional (expert/patient) relationships.’

Rather than defining PS, it has been argued that it is more helpful to view PS services as sharing a number of common values (Clay, 2005). The Consumer Operated Services Program developed a list of common ingredients found to underlie the different PS programmes (Campbell, 2008). Figure 1 summarises the critical ingredients, based on the Fidelity Assessment Common Ingredients Tool and developed by MH service user providers (Clay, 2005).

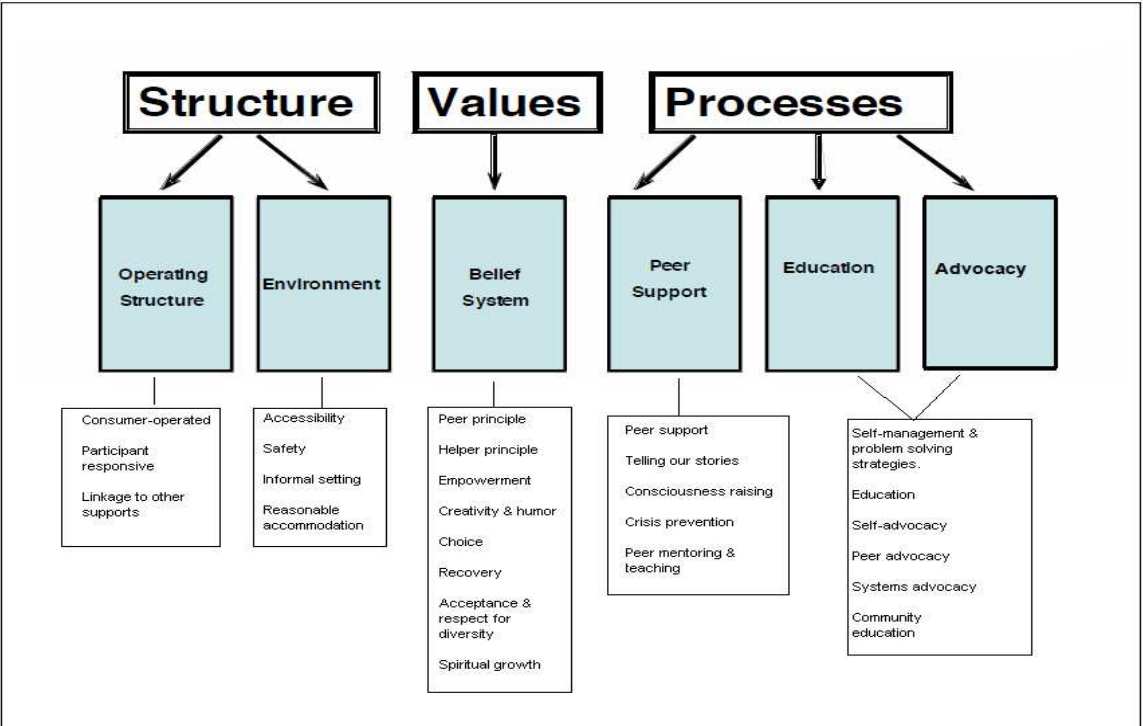


Figure 1. COSP common ingredients by category adapted from Clay (2005)

These principles, in particular the peer principle and helper principle have been considered the cornerstones of PSW and have been incorporated into much of the research supporting the efficacy of formal peer run services (Woodhouse & Vincent, 2006). The two ideologies emphasise the equality and reciprocity of support and the understanding that helping others in their recovery, provides further support for personal recovery.

Although it can be useful for an evolving role to be flexible both in definition and duties of the role, problems may exist. The Scottish Capital Investment Manual (SCIM) offers guidance in an NHS context on the processes and applied methods when considering the development of infrastructure projects (SCIM, 2010). The manual states that the National Audit Office and the Office of

Government Commerce have identified that a lack of processes in place to ensure all parties have a clear understanding of their roles and responsibilities is related to common causes of project failure.

In relation to the current research, I considered the personal specification and vacancy details of the job for the PSWs who participated in the study (see Appendix E). It was hoped that this would provide a better understanding of the meaning of PS. This explained:

Through sharing wisdom from their own experiences, PSWs will inspire hope and belief that recovery is possible in others. As an integral and highly valued member of the multi-disciplinary team, the PSW will provide formalised peer support and practical assistance to people who use the service in order for them to regain control over their lives and their own unique recovery process. Within a relationship of mutuality and information sharing, they will promote choice, self-determination and opportunities for the fulfilment of socially valued roles and connection to local communities.

The personal specification further detailed the essential requirement of PSWs having lived experience of MH difficulties. In addition to this requirement, it outlined the need to have experienced recovering a meaningful life and being in a supportive and enabling role. Desirable experiences included psychiatric hospital admission, experience of working in the public sector, in a team, across different organisational boundaries and experience of using a range of self-management or recovery tools and techniques. Although the job details offered a clearer relation to the philosophical underpinnings within the PS literature, I was left wondering what this might mean for individuals practically in relation to transitioning into this role. Furthermore, I was left speculating, apart from the 'lived experience', how different was the role from that of a mental health support worker?

Although a rationale has been provided for the lack of definition within the PS literature, a more fundamental problem exists. Mead's (2003) theoretical understanding of PS cannot be translated into practice through the current method of recruitment for PSWs. Mead (2003) stipulates that PS is not based on psychiatric models and diagnostic criteria, yet the essential criteria of a PSW role is lived

experience of MH difficulties, which is often classified using these very models and criteria. Furthermore, experience of psychiatric hospital admission is listed as desirable. Rather than the PSW role moving away from the traditional (expert/patient) relationships and acting to breakdown the boundaries between them, it simply reinforces the status quo. If the job description and personal specification refrained from using a medicalised framework, it would be difficult to differentiate the role of a PSW from that of a support worker, and perhaps undermine the underpinnings of what makes PS unique. Again this raises questions around how the role is practically enacted and whether this fundamental problem becomes apparent when individuals transition into the role.

2.3 Current policy supporting peer support in the UK

In the 1980s, the NHS management enquiry recommended that consumers of health care should be involved in future developments and evaluation of services (Griffiths, 1983). The principle of service user involvement is now generally supported and explicit in most statutory and voluntary initiatives (Robson, Begum & Locke, 2003) and endorsed across varying levels of service relations; from individual encounters (e.g. Scottish Executive Health Department, 2006) through to service management (e.g. Department of Health (DoH), 1999) and strategic planning both locally (e.g. DoH Social Services and Public Safety, 2000) and nationally (National Institute of Mental Health in England, 2007). Section 242 of the consolidated NHS Act (DoH, 2006) makes it a legal requirement for NHS trusts, primary care trusts and strategic health authorities to involve patients and the public in planning, operation and development of services. One aspect of satisfying this requirement is the implementation of PS services.

PS has been recognised as an important factor in recovery (Repper & Carter, 2010). The concept of recovery from mental illness is a relatively recent development (Anthony, 1993). Although opinions about recovery are wide-ranging, recovery is a central focus of MH policy, guidelines and framework (DoH, 2009a). One recovery-orientated approach is linked to recovery and economic independence. Warner (2010) terms this “social recovery” (p.3) and provides evidence on a macroeconomic and individual level to support the ethos

that employment is an integral part of recovery from mental ill health. One possibility for employment of service users is within MH services. The government's vision for MH care states that "all mental health services will be expected to recruit and train service users as part of their workforce" (DoH, 2001, p.21). The Sainsbury Centre of Mental Health (2009) is more radical in its expectations and envisages a fundamental shift in the NHS workforce to incorporate a mass expansion of 'peer professionals' (up to 50% of the entire workforce) accounting for a much larger percentage of currently employed NHS staff. Although this aspiration is perhaps overly ambitious, the Mckinsey report (DoH, 2009b) offers some support for the vision. The report was compiled in order to offer NHS commissioners advice on reducing costs and improving productivity. It denotes that cost efficiencies within the NHS can be achieved through increased service user provided services and the reorganisation of the workforce. Making use of people who have MH problems to reduce costs and to enable efficiency within services could simultaneously promote recovery. However, policy drivers neglect to consider the impact of such transitions and how in practice it may counteract recovery.

In summary, PSWs are one way of incorporating the aims outlined by the governmental policies. It supports the involvement of service users in the planning and development of services and partnership working complements a recovery-focused approach and it offers the potential to provide a more cost efficient NHS. Modern MH services are in theory complementary to the principles outlined in section 2.2 (Repper & Carter, 2010) and therefore minimal disruption should occur when implementing them through PS. However, the next section details the barriers to the successful transitioning of these principles in addition to the literature outlining the efficacy of PS, the benefits and general limitations.

2.4 Current research on providing peer support

Although in its infancy, there is a growing body of international research which encapsulates the value of PS as good evidence based practice. The rationale for a more service user-led approach to managed care derives from positive

outcome measures. One outcome measure often used in PS services is reduced hospitalisation for those receiving PS and the implications of saving costs within MH services (Woodhouse & Vincent, 2006). However, the ability to effectively measure this is questionable. Research has appraised the evidence from controlled studies for effectiveness of service user-led MH services, including PS services and overall, found equally positive outcomes compared to traditional services (Doughty & Tse, 2010). When measuring self-esteem and self-efficacy, Bracke et al. (2008) found that providing PS is more beneficial than receiving it. Personal benefits gained through providing PS have suggested it facilitates recovery, fosters social approval, professional development, and mutual support and provides financial rewards (Mowbray et al., 1998; Salzer & Shear, 2002). Helping others has been shown to increase feelings of competence and meaning (Skovholt, 1974). Nevertheless, studies have also demonstrated that people having to make a transition into providing PS can be harmful and can lead to negative emotions and burnout (Bracke et al., 2008; Mowbray et al., 1998). There is currently a lack of in-depth qualitative research exploring the experiences of recovery within a PS framework and quantitative research to evaluate the validity and reliability of these key principles in order to better understand the relationship between the effects of PS and recovery. Presently, the assumptions around recovery and PS remain aspirational rather than grounded in empirical research. Furthermore, there is a dearth of in-depth understanding of how the transition may be harmful.

Stigmatising³ attitudes toward individuals with mental illness are widespread (Angermeyer & Dietrich, 2006) and continue to be a problem for the stigmatised person in addition to key clinical and public health issues (see Thornicroft, 2006; Hinshaw, 2007). Using regression analysis of structured questionnaires, Verhaeghe, Bracke and Bruynooghe (2008) examined whether PS could diminish the negative association between MH and stigmatisation. Their findings revealed that stigmatisation was negatively associated to self-esteem, while PS was positively associated with it. Upon closer examination, their results suggest that PS can only have positive outcomes when RPS have a small number of stigmatising

³For the purpose of this thesis stigma is referred to as the social disapproval or of personal discontent because of an individual's mental illness.

experiences⁴. Research has also suggested that individuals providing PS were less inclined to report stigma as a barrier for employment (Ochocka, Nelson, Janzen & Trainors, 2006). However, research has failed to capture the complexities of how individuals make sense of transitioning from an often stigmatised position to one where they are less inclined to report stigma as a barrier for employment and indeed whether other barriers continue to exist.

When facilitating the work transition into the PS role, the need for properly defined and established roles has been emphasised (Repper & Carter, 2010). Appraising the PS literature, Davidson et al. (2006) attempted a workable definition of the PSW role which was loosely based around possible functions. These included: offering understanding, acceptance, empathy, role modelling, practical support and information, offering coping strategies, problem solving and offering recovery-orientated perspectives. Although Davidson et al. (2006) have endeavoured to conceptualise the role, their definition could be interpreted in many ways. Consequently, there has been considerable variation as to how PSW roles are understood (Meehan, Bergen, Coveney & Thornton, 2002; Moll et al., 2009; Richard et al., 2009).

Role vagueness, role difficulties and blurring of boundaries have previously been reported to be a challenge for people making a transition into providing PS (Mowbray et al., 1998; Salzer, 2002) although there is limited research exploring these perceived challenges and how they may be addressed. A lack of supporting policies and practices has also been identified as a barrier to successful implementation (Gates & Akabas, 2007). Previous research has outlined the challenges associated with establishing effective relationships with staff teams, particularly with interprofessional working and PSWs being viewed as a valuable member of the team, rather than cheap labour (Gates & Akabas, 2007). Fitting in or being accepted in the workplace can be a key transition point (Moll et al., 2009). Being welcomed and supported by other staff members can assist this whilst practicalities of the job including limited hours, can prevent PSWs from being able to properly integrate within the teams (Moll et al., 2009). The research outlined in this

⁴For example, individuals with no previous full-time hospitalisation and those who have lower stress and more social support.

paragraph raises questions around the job description offered in section 2.2 and how individuals make sense of delivering a supportive and enabling role as an integral and highly valued member of the multi-disciplinary team whilst possibly experiencing the above challenges.

In summary, the research has described both benefits and challenges to PS and the working conditions that are needed to support its implementation. However, it is important to acknowledge that all of the above studies were conducted outside the UK and although the research could contribute to the understanding of PS within England, they are culturally specific. Furthermore, training was largely based on American policy and practice and is therefore subject to interpretation within that locality. Finally, the research begins to consider the integration of PSWs into a MH setting and their general experience, but fails to address how individuals make sense of transitioning from their own lived experience of MH difficulties to providing a service to support others. It is important to research this area and examine what supports and impedes this process in order to enable the successful implementation of policy commitments that endeavour to increase service user provided services and expand PS services.

2.5 Existing research in the UK on providing peer support

There is currently a dearth of research into employed MH PSWs in the UK which is perhaps a reflection that this initiative is in its early stages of development. However, two literature reviews (Repper & Carter, 2010; Williams, 2011) have outlined pilot projects that are currently utilising paid PSWs in both Scotland and England.

Williams (2011) offers an overview of the existing literature of PS and emphasises the promotion of using and valuing PS and enabling these resources to be “accessible to a wide audience” (Williams, 2001, p.1). The review highlights instances of where PS may be beneficial and outlines current projects within NHS MH Trusts. However, the review lacks clear aims,

incorporates a vague research strategy and fails to review the evidence outlined in a systematic way, thereby preventing a replication of the review and the specific evaluation of each studies contribution to the literature. Furthermore, Williams (2011) does not offer any critical appraisal of the written material or outline any possible competing interests. Consequently, this questions the validity of the argument that “peer support deserves to be championed across MH service and community” (p.12).

Repper and Carter (2010) provide a more systematic search strategy and data analysis with three clear aims. However, they do not consider an assessment tool which could have been applied to the appraised literature and supported a comprehensive assessment of the whole paper being reviewed. Again the review fails to identify strengths and weaknesses of the reviewed literature. Instead the focus is upon using the available evidence surrounding PS in MH services in an attempt to clearly define and distinguish PS and determine ways in which it could be implemented more effectively. Finally, it does not address competing interests⁵. The research within the reviews may be credible and the findings of the two literature reviews may be meaningful but are currently obscured by a limited critical appraisal of the reviewed studies, a lack of replicability and unclear author bias. Therefore, more thoroughly appraised reviews are required within the PS literature which can address these problems.

The Scottish Government has recently commissioned PSWs after piloting the PS scheme since 2005 (McLean, Biggs, Whitehead, Pratt & Maxwell, 2009). Although McLean’s et al. (2009) research was not examining the transitional experience specifically, their findings incorporated aspects of the PSW transition, which highlights the relevance of exploring the transitional experience in greater detail. They found that PSWs mostly grew in confidence and experienced ‘enhanced recovery’. Although their results did report on some PSWs becoming

⁵The main author is currently leading the development of PSWs training and employment in her local services and it is unclear what measures were incorporated to reduce possible biases within the review.

unwell during the pilot scheme, they were able to implement constructive use of their experiences of recovery. The study also reported challenges associated with establishing effective relationships with staff teams, particularly whilst challenging non-recovery focused practice (McLean et al., 2009). However, the study failed to expand on what non-recovery focused practice was. Nevertheless, the research did emphasise the impact that PSWs can have on bridging the 'them and us gap' which it argued invariably exists between service users and the MH system. Again this raises questions with the PSW role and the need to view 'service user' and 'professional worker' as separate entities. The journal article has highlighted the lack of research exploring how individuals transitioning into PS make sense of this phenomenon.

Two recent qualitative studies have been conducted to evaluate a PS specialist training programme (Gerry, Berry & Hayward, 2011) and to explore the experience of PSWs in their new role and its contribution towards recovery based practice within the context of the NHS (Stone, Warren & Napier, 2010). Employing thematic analysis and semantic coding, Gerry et al.'s (2011) findings suggest the training had a positive personal impact, whilst wider issues concerning PSW NHS employment included; a gap between Trust recovery policy and actual practice, the perceived lack of Trust commitment towards a PS service and the scepticism of being entirely accepted as full and equal members of the current NHS workforce. Stone et al. (2010) applied content analysis to their results and reported participant descriptions of personal growth, adaptation and challenges. In particular the importance of developing new relationships, managing own wellbeing and developing a 'peer' identity were highlighted.

These two qualitative studies have highlighted some aspects of the PS transition that may warrant further investigation. However the level of enquiry for both studies was descriptive and failed to capture phenomenological experiences of how participants made sense of the transitioning experiences. Furthermore, both studies utilised a focus group design, limiting the opportunity to gain an in-depth understanding of the individual experience. Group dynamics may constrain individual responses because of an inclination to acquiesce with other

participants or their voices are overshadowed by dominant speakers (Barker, Pistrang & Elliot, 2002).

Recovery and peer support

Recovery is a pivotal element of the PSW role, in both exemplifying it and promoting it in RPS and has been focused upon in the above studies. However, concerns have been reported that recovery has been appropriated by NHS MH services to accommodate their already established structures and consequently contradictions persist about the use of recovery by services (Trivedi, 2011). For example, the acceptance of personal journeys and then the implementation of structured models with distinct stages and standardised outcome measures (Trivedi, 2011). Further research has outlined that potential conflicts between PS in its basic formation and its configuration of paid PSWs in statutory settings may become problematic because of differing values and priorities (Ley, 2010). Faulkner (2011) contemplates the essence of 'peer' in the PSW role and argues it is lost when individuals are in a paid and intentional role working to service guidelines. She contends it initiates a level of division and power differentiation that would not otherwise have been there. Moreover, Shaw (2011) highlights that the current cuts in health and social care may provide an ideal climate to employ PSWs as a cheap alternative to qualified staff. He further expresses his trepidations that PSWs will be expected to undertake duties that these staff had, including the monitoring of compliance, delivering of drugs, control and restraint and forced medication. Presently, research has not suggested that these fears have materialised but they do raise important questions about how this may contribute to an individual making sense of their transition into providing PS, particularly when previous research has highlighted the lack of clarity in defining the PSW role and it being understood in different ways (Meehan et al., 2002; Moll et al., 2009; Richard, Jongbloed & MacFarlane, 2009).

Whilst there is some research developing in the UK about PSWs experiences, the focus is predominantly on the training provisions, the recovery-focused links and generating support for its implementation. Basset, Faulkner, Repper and

Stamou (2010) emphasised the requirement of further research to explore the emergence of PSWs and what supports and impedes the enactment of the role. The current research endeavours to contribute to the existing understanding of employed MH PSWs in the UK by addressing the methodological limitations outlined in the two UK studies and by exploring the transitioning experiences of PSWs. It is argued that this will provide a better understanding of how PSWs make sense of their experience in the context of their 'peer identity' within the NHS organisation and what impedes and supports that transition.

2.6 The importance of better understanding of role enactments, transitions and identities when considering peer support

When exploring the transitioning period for individuals being employed as PSWs, there are a number of theoretical concepts that could be applied. Previous postulations have been provided that may perhaps explain the psychological processes underlying PS. These have incorporated social learning theory, social comparison theory and the helper-therapy principle (Salzer, 2002). The following sections consider the psychological concepts; identity, organisational culture and role transitions. Additionally the rationale for their possible relevance within the current study is detailed.

Self-identity, social identity, work identity and organisational culture

Previous research on PSWs has highlighted identity issues around role confusion, professional boundaries and the 'peer identity'. Identity has been the subject of theoretical and empirical analysis over the last century. Jacobson (1998) identifies "two broad types" of theory on identity. The first is personality theory, which sees identity as "a sense of personal distinctiveness, personal continuity and personal autonomy" (p.4). The second perspective on identity is based on social psychology, and has "a sense of identity formed from a dialectic between the individual and society" (p.4). It is beyond the scope of the current research to offer more than a glimpse into the self and social identity, with a particular focus on PSWs.

The study of personal identity development is evidenced in Freud's (1930/1965) early postulations that identity is not stable or rational, but an ever-conflicted tension between id and ego, conscious and subconscious mind. For Erikson (1968) personal identity embodied the amount of self-knowledge, synthesis and consistency that a person occupied over time and in different contexts. It was not something formed at birth, nor was it independent from biological processes. He argued it was not the physical body itself, nor the Super-Ego or Ideal-Ego alone. Erikson defined identity as a constant reproduction of images of self, experienced and put together by an individual. He proposed a single bipolar dimension in his psychosocial developmental model. When the various aspects of an individual's identity fits together, *identity synthesis* exists, with Erikson (1974) arguing that this predicted positive correlations of psychosocial functioning. At the opposite pole, *identity confusion* breeds a lack of purpose and direction. For Erikson, the emergence of an identity crisis occurs during the teenage years, when individuals struggle between feelings of identity versus role confusion. Marcia (1966) refined and extended Erikson's model, paying particular attention to adolescent development. When considering Erikson's concept of identity crisis, he hypothesised that the adolescent stage does not represent identity resolution or identity confusion, but rather the extent to which one has explored and committed to an identity in a variety of life domains (i.e. occupation, religion, relational choices, and gender roles). *Exploration* denotes a sieving through prospective identity options and *commitment* represents a decision and adherence to a particular set of goals, values and beliefs.

The notion of stages of identity has been subject to criticism. For example, when considering a model of sexual orientation, Kaufman and Johnson (2004) argue it is less valid today because it does not take into consideration socio-cultural factors which can influence identity development and the changing nature of social stigma. Additionally, the linear aspect of the model implies that if an individual abandons the model or is unable to succeed through stages, they would not be considered to be well adjusted, which Kaufman and Johnson (2004) argue is not necessarily true. This criticism could also be levied at the other models which encompass stages of identity development.

Recently, researchers of identity development have retreated from the idea of the development of identity being linear and complex-free, with recognition that these models classify people as the same with failure to recognise within-group differences. Finley (1997) explored the fluid and dynamic quality of identity and found that “multiple identities followed overlapping, interweaving spirals of development” (p.3921). Her study hypothesised that environmental influences are interrelated with developmental progress and outside groups contribute, as does maturity, self awareness and a deepening of spirituality. The term ‘identity’ is often found in social constructionist literature. Burr (2007) writes “our identity is constructed out of the discourses culturally available to us, and which we draw upon in our communications with other people” (p.106). Burr attributes identity to “a subtle interweaving of many different threads” incorporating age, gender, education, ethnicity, sexual orientation and income etc.

Jones and McEwen (2000) advocate a conceptual model of multiple dimensions of dynamic identity believing “intersecting circles surrounding the core identity represent significant identity dimensions (i.e. race, sexual orientation and religion) and contextual influences (i.e. family background and life experiences)” (p.405). Their research found participants understood identity dimensions as “both externally defined and internally experienced, and also influenced by different contexts” (p.411). From Finley’s research to Burrs epistemological stance, contemporary identity is seen today as more multidimensional, mobile and interweaved with external influences.

In Summary, the literature outlined has demonstrated the interest over the years of various authors attempting to construct developmental models of identity. Disputes have been identified as to whether internal or external factors (and conflicts) are more significant and whether one should rely on a single model of development or a model of multiple dimensions of the self. Multiple dimensions of the self seem to fit particularly well with social identity.

Oyserman’s (2004) conceptualisation of identity involves answering the questions “who am I?”, “where do I belong” and “how do I fit?” Despite the

emphasis on I, Oyserman argues the self is only significant in the context of relationships to others and position in social groups. However, what is meant by the self in research and theorising is often quite ambiguous, Suler (1998) previously summarised this by explaining:

The concept of self is a bit like the concept of energy. We talk about it all the time, we see the effects of it all around us, we try to manipulate it. But no one is exactly sure what it is. (Suler, 1998).

Tajfel and Turner (1979) developed the Social Identity Theory (SIT), suggesting that people have an inbuilt tendency to self-categorise into one or more in-groups, structuring part of their identity on the basis of membership of that group and enforcing boundaries with other groups. This process, aided by *social categorisation* (ability to categorise objects) helps us with a sense of who we are, based on group membership. Furthermore, Tajfel (1981) reasoned that while we are likely to view people who belong together in the same group as comparable in most ways, we tend to exaggerate the differences between out-groups, which are likely to be the root of prejudice in all its forms. SIT further reasons that once we self categorise, we then *socially identify* and adopt the identity of the group we have categorised ourselves as belonging to. Finally, the model suggests we *socially compare* the in-group with out-groups and in order to maintain self-esteem, the in-group needs to compare favourably to other groups. If two groups are seen to rival each other, they are forced to compete in order for the members to maintain their self-esteem. SIT also explores how social differences in power affect identities and how some members of subordinate groups use 'social mobility' to develop their position by rejecting their previous group and advancing to another. Initially, it may be considered that SIT sees society as more influential than the individual. However, it has been criticised for treating groups as if they were individuals because the research asks individuals to behave in this manner. Consequently, it has been argued that this then underestimates important social differences (Phoenix, 2006, p.30). Although SIT may be useful for understanding the transitional experiences of PSWs, it provides quite a simplistic explanation to out-group and in-group processes. There is little exploration of the more complex and context dependent interaction between group affiliation and identifying with a number of groups, which at times, may be

conflicting within the workplace (such as the PSW, professional, friend identity). It was felt that relying on this theory in its entirety would not be helpful for understanding the experiences of the participants in this research.

Scholars frequently promote identity as a “novel interpretive frame in the analysis of organisations” whilst exploring how individuals negotiate issues in relation to the self and the workplace (Alvesson, Ashcraft & Thomas, 2007, p.7). Work-placed identities are often considered using social identity and symbolic interactionist theories (Jones & Volpe, 2011). Identity in the context of the NHS and government policies and practices, lies at the heart of modern democratic politics, and has implications for personal and collective identity (Parekh, 2008). Parekh sees the individual as possessing three inseparable components of identity: the personal; the social (member of a particular group); the human (universal community). He argues that every society, generally, is a well-expressed system of identities, subjected to norms, beliefs and privileges and governed by formal and informal sanctions. Parekh (2008) further contends that we strive for a shared and inclusive sense of belonging at a community and national level and by doing so, we can develop a globally orientated citizenship. Parekh draws on idealist accounts of reality and thereby is sceptical about the possibility of knowing any mind-independent thing. I’m more pragmatic and focus on how the world is presently with a belief that there is a stable and underlying reality but multiple perspectives and sense-making relate to this reality. Additionally, it was felt that a model specifically considering work transitions and identities would provide more insight than one that focused more broadly on community, national and global identities.

According to Ebaugh (1988) when considering roles within a particular identity (such as PS identity) they can be viewed as “sets of behavioural expectations associated with given positions in the social structure” (p.18). Subsequently, roles represent basic formations within organisations whereby sense-meaning and rationale of a given role is dependent on the system of complementary roles within which it is embedded (Biddle, 1979). Therefore, it is argued that when the term role is used, it will inevitably be followed by reference to interaction (Stryker & Statham, 1985). Sluss and Ashforth (2007) reason that self-definition within an organisational context is partially determined by an individual’s network of interdependent roles in addition to the personal identity and collective identity. Subsequently, this could

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have many implications for PSWs entering the NHS and this research is interested in how an individual shapes their role and indeed identifies with that role, others and more widely the NHS culture. How does an individual make sense of what is happening to them and the transition they have made?

Finally, culture and organisations are important to consider because the context of the transition is a work organisation, specifically the NHS. The NHS was created in 1948 and is one of the largest employers in the world, employing around 1.3 million people (NHS, 2008). Davies & Mannion (1999) reported that in the 1990s there was a focus on increased management and accountability in the NHS, with a development of a “business culture”. The Labour Government directed a cultural shift towards “improved quality of care” (DoH, 1998). The meaning of organisational culture is ambiguous. It can be viewed as tangible and measurable (Shortell et al, 2000) or an integral part of an organisation which cannot be separated (Langfield-Smith, 1995). Either way, Matsumoto and Juang (2004) argued that an organisation embodies a structure formed by individuals working collaboratively, in order to obtain certain organisational objectives and general goals, even when they may have different specific goals, shaping attitudes, beliefs, norms and behaviours. When individuals experience change, such as a change in role, social support assists this (Monroe, 1983) and can develop psychological well-being (Furnham, 2004). In relation to culture, Furnham (2004) explored differences in values existing between cultures to account for the misunderstandings, distress and difficulties experienced by individuals in a new culture. The research found that individuals needed to be sensitive when responding to the environment but also adapt a flexible behavioural repertoire which can “respond appropriately to social milieux” (Furnham, 2004, p.201). Tait and Lester (2005) believe service user involvement, such as PS services, compels organisations to analyse their own cultural environment. They assert that service cultures that advocate involvement tend to demonstrate a commitment to genuine partnerships between users of MH services and professionals and develop shared objectives. Section 2.3 detailed the current policy supporting the PS, however previous research has highlighted that the NHS organisation and its policies and practices could be a barrier for the successful implementation of PS (May, 2010; Repper & Carter, 2010; Trivedi, 2011).

Role Transitions

The word 'transition' involves change, and change has consequences for the identity of the person experiencing it (Petch, 2009). Transitions are a recurrent theme across an individual's lifetime with varying degrees of frequency and severity. They can be seen as a process rather than a single event, a period of adjustment and recalibration (Williams, 1999) of "changing from one set of expected positional behaviors in a social system to another" (Allen & van de Vliert, 1984, p.3). Transitions have been studied when exploring trauma and loss, but research suggests that life events e.g. new job can potentially initiate psychological disruption (Williams, 1999). It can create uncertainties and a potential change of position may generate anxiety and distress. Even if the transition is viewed positively and provides opportunity for growth, it can cause uncertainty and doubt because there is a period of readjusting psychosocially into unpredictable conditions (Petch, 2009). Coping responses, such as commitment, willingness and social networks are considered to aid transitions (Pearlin & Schooler, 1978) suggesting the importance of personal and social resources. Kobasa (1979/1986) expanded on this and argued that certain individuals are better able to cope with stressful life events (such as major transitions) because of individual characteristics and personal traits. Comparing two groups of executives who had experienced similar stressful life events and finding one group had become ill, whilst the other had not, lead Kobasa to develop the concept of 'hardiness' to explain these differences. She claimed individuals were 'hardy' enough to manage these stressors because they felt an element of 'control' in influencing their lives, 'commitment' with strong social bonds and viewed the change as a 'challenge' rather than a threat. However, criticisms have been voiced around the unfeasibility of being able to effectively measure and operationally define hardiness (Greene & Nowack, 1995).

Ashforth (2001) further supports the concept of a transition being supported when a change is seen as a challenge and not a threat (Ashforth, 2001). Ashforth (2001) examines role transitions and the consequences for identity and status. He purports that as individuals exit one role and enter into another they experience a number of changes that interrelate with an individual's global self-identity. Many role transitions are driven by psychological motives whereas others are seen by Ashforth as

necessitated by changing life circumstances. Various models of transition (e.g. Ashforth, 2001; Fisher & Savage, 1999; Hendry & Kloep, 2002; Adams, Hayes & Hopson, 1976) have attempted to outline how individuals respond to change and may provide insight to an individual's move from their own lived experience of MH difficulties to providing a service to help others with their MH difficulties. The identification of transitional stages may help PSWs and staff to better understand the experiences of individuals transitioning into PS and to recognise the emotions that can be aroused by such transitions.

Figure 2 depicts Allen and van de Vliert's (1984) framework which comprises of a number of components that attempt to aid the understanding of the nature and the potential impact of role transitions.

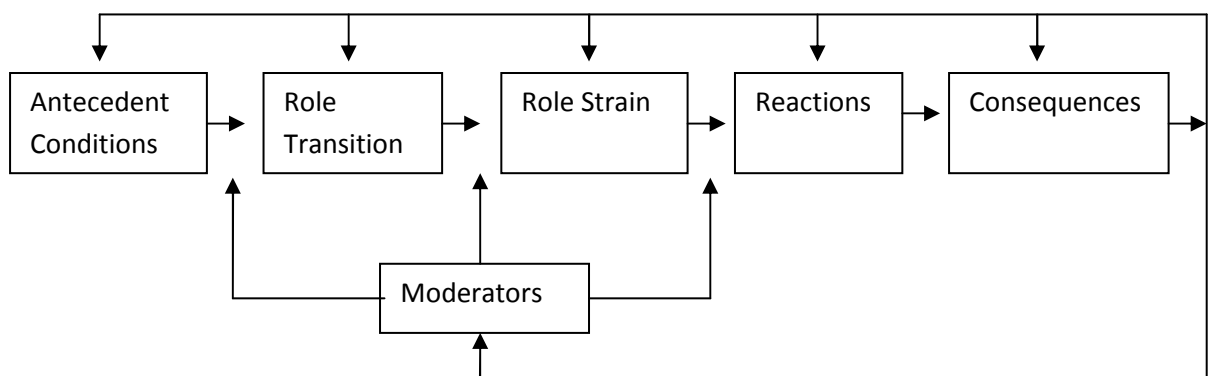


Figure 2. A Model of the Role Transition Process (Allen & Van de Vliert, 1984)

Antecedent conditions are the events or conditions that lead to a potential transition and can be planned, forced or caused by chance. *Role transition* comprises of the changes that are likely to occur but are mediated by three conditions: the amount of discontinuity between the previous and latest role expectations, the level of control the role holder has over the transition, and the degree to which the role transition is affected by normative governors (i.e. graduation or promotion). *Role strain* signifies the mental state of the role holder experiences during the role transition. *Moderators* are both the individual and environmental variables that may intervene between the initiation of role transition process and consequent responses by the role holder. *Reactions* refer

to activities that the role holder incorporates in an attempt to reduce the amount of role strain and incorporates; affective, perceptual/cognitive and behavioural responses. Finally, *Consequences* include the total effects and impact of the role holder's reactions to role strain and can be both short-term and long-term. This occurs when feedback to other components of the model is provided and will either reduce, increase or not change the amount of experienced strain (Allen & van de Vliert, 1984). This framework provides a general model for analysing the psychological processes associated with role transitions, but does not capture all aspects of the transitioning process. Additionally, there is a lack of understanding of the nature of the relationship between the components (Allen & van de Vliert, 1984) and it relies on a sequential process, which may be an inadequate portrayal of a transitional experience.

Limited research exists on the subject of conflicting identities in relation to one role blending with other roles. Sluss and Ashforth (2007) attempt to develop a relational identification model, capturing the intricacies in which an individual defines him or herself in terms of role relationships, whilst also relying on the self and the social identity. They argue that relational identity integrates conceptions of role identity and self-construal, and thus contains both collective and individual elements. They contrast relational identity and relational identification and hypothesise novel constructs of "relational disidentification" wherein negative views of attributes about oneself coincide with negative attributes of a relationship, and "ambivalent relational identification" wherein the self-construal and the relational identity are discordant. Thus, individuals may vary their identification with co-workers depending on the type of identity that is activated. However, they do not address gender, which may be an influential factor (Collinson, 2003). Furthermore, the model emphasises interpersonal relationships between one individual and one co-worker and does not permit us to consider the multiple work relationships characterising a role enactment. Although this is not to say it cannot be considered using this model.

Furthermore, models of transitions and their stages may not always be experienced by people in the particular sequence outlined and individuals do not always conform rigidly to set patterns (Sidell, 1993). Additionally, the models often fail to adequately

explain variations in people's experiences. There are numerous variables which affect personal responses to transitions. It is therefore important to explore how each individual experiences the process and expresses their feelings about it. Instead I felt it was helpful to consider the transitional experience as possibly influenced by internal and external factors and to consider not only the transitional theoretical approaches but also the impact of role relationships, social identity and environmental factors. Sluss and Ashforth's model (2007) partially supports this consideration. However, this research recognises that it too is restrictive and is not without its limitations. Therefore, it was felt that an adaptive model was needed that considered external factors and would be used flexibly.

Figure 3 provides a diagrammatic synthesis of the above literature and stresses the relationship between the personal (self), the collective (social identity) and the interpersonal role relationships (role) within an organisational setting. This core experience is then placed within a wider context whereby there are further factors influencing this transitional experience, such as sociocultural and political conditions.

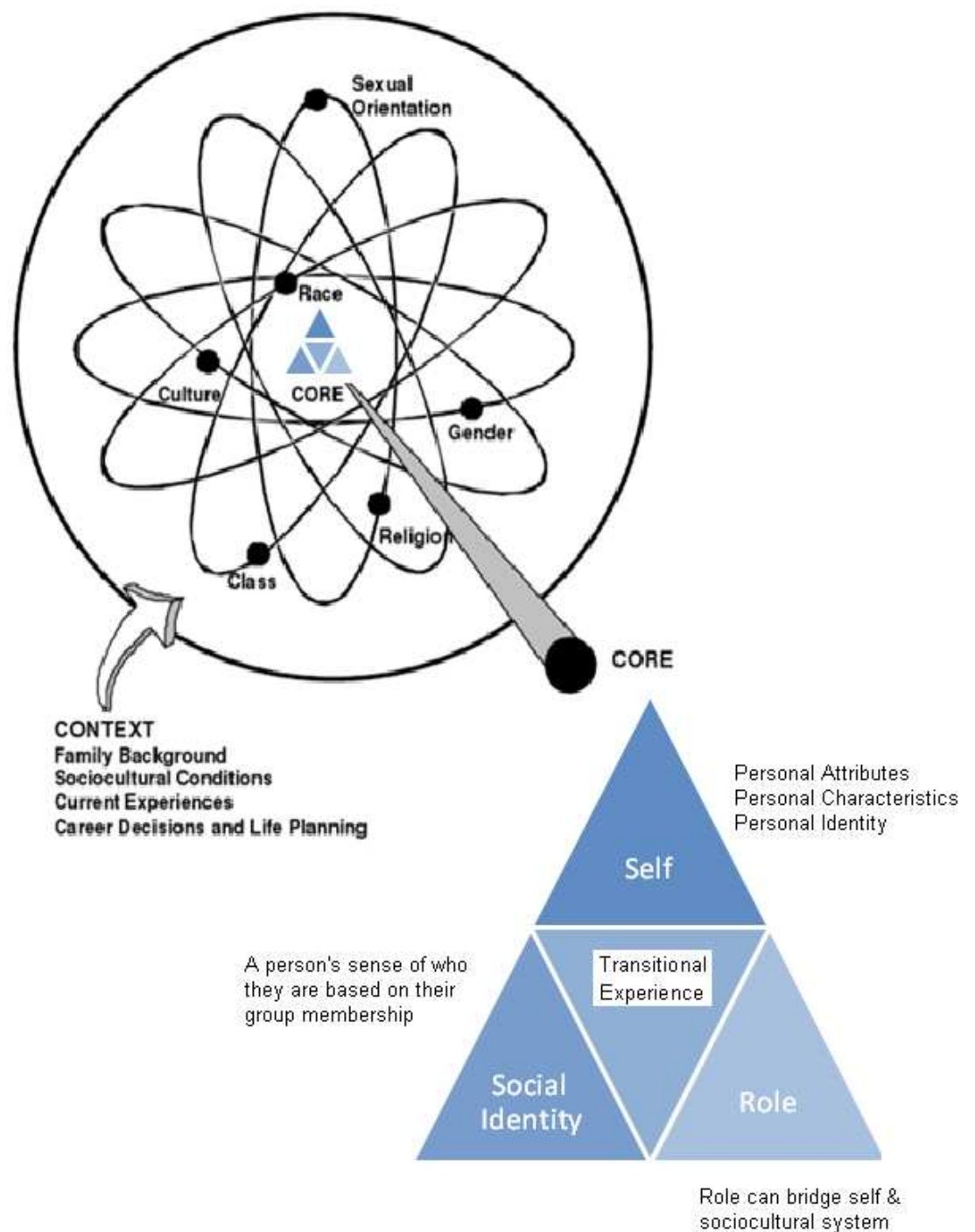


Figure 3. Model of Multiple Dimensions of Identity and Transitional Experience:
Adapted using Sluss and Ashforth (2007) and Jones and McEwen (2000)

Wider research on NHS transitions

The wider research exploring four professional groups⁶ and their experience of entering the NHS, suggests that policies supporting transitions into NHS services may be confronted with key issues (Thomas et al., 2008). These issues are i) addressing diverse needs in relation to change, ii) integration of profession-specific policies and practices and iii) their configuration with employee policies intended to modify boundaries and increase interprofessional working (Thomas et al., 2008). The study suggested that difficulties of working interprofessionally were exacerbated by the unfamiliarity between professional groups of each other's needs and expectations. The study concluded that "significant aspects of current practice do not match contemporary policy requirements" in relation to interprofessional working (Thomas et al., 2008, p.27). Previous research has also considered the dual roles that exist with professionals within the NHS, exploring individuals transitioning from a practitioner identity to becoming a nursing academic (Andrew, Ferguson, Wilkie, Corcoran & Simpson, 2009) and the dual roles of medical and management professionals (Huxham & Bothams, 1995). Both papers highlight the key challenges, problems and limitations of the duality and the tension in satisfying the demands of the two roles. Huxham and Bothams (1995) further emphasised the need to work with other clinicians to help support the acceptance of the dual role. Although the purpose of the transition and the dual role is different to PSWs entering the NHS, the current research could provide important information currently missing within the PS literature. Similar to the participants in Huxham and Bothams' (1995) study and Andrew, Ferguson, Wilkie, Corcoran and Simpson's (2009) research, PSWs will be managing dual roles; the role of a professional and the role of having lived experience of MH. There is also the possibility that some of the PSWs will be employed within a service whilst simultaneously receiving services. Repper and Carter (2010) recommend that further research is needed to consider the dual relationships experienced by PSWs. Recent research has suggested that difficulties occur for PSWs when managing their dual role as 'patient' and worker (Daniels et al., 2010); although the exploration does not go beyond identifying that dual role stress can exist. Therefore, further in-depth research is warranted in better understanding how PSWs encounter these dual relationships. This seems particularly pertinent given that some scholars argue that PSWs are eager to

⁶Dentists working in the community dental service, children's nurses, pharmacists and radiographers

distance themselves from a 'professional role' (Repper & Carter, 2010) and that previous research has suggested that transitioning experiences can be hampered by a lack of interprofessional working (Thomas et al., 2008).

To summarise, social and personal identity, organisational culture and the concept of role transitions could be significant areas to consider when exploring an individual's experience of transitioning into providing PS. Despite this, there has been little research exploring these areas. The current study endeavours to address this gap in the PS literature, but I am also mindful that although I have considered possible theoretical underpinnings related to PS, my research will be directed by the data and any theoretical propositions will be "derived from and [be] grounded in, rather than predate[s] and constrain[s], a body of data" (Smith, 1999, p.412).

2.7 Rationale

Although the PS literature within England has provided some insights into the transitional experience for PSWs, there is a lack of in-depth analysis exploring this process. Furthermore, research on PS in MH settings is not always based on one-to-one interviews, not always limited to a community service and incorporates different sample sizes and different stages of transitions. These contextual differences between individuals and studies may have caused variations in how the experiences of PSWs were reported and these potential differences were not always acknowledged. The current research hopes to also address some of these methodological limitations.

Drawing on the wider literature of role transitions, organisational culture and identity, this research aims to supplement the limited understanding of an individual's reflections and sense-making when transitioning from their own lived experiences of MH difficulties to supporting others with their MH difficulties. This research aims to identify potential or real barriers to a successful transition, so that these possible barriers can be addressed and unrealistic expectations avoided for the present participants and perhaps future PSWs. Articulating these aspects could help secure

the organisational and resource commitments to promote a culture of genuine participation with service users. The proposed research potentially has implications for the interpretation and implementation of policy and practice. It aims to promote policy and practice that can enable these transitions to be achieved with the most effective outcomes for the individuals concerned. It may also benefit anyone who is at the start or in the early stages of their journey of involvement and offer insights into practical issues, together with emotional and cognitive processes relating to transitions.

The research question is:

How does an individual make sense of their experience of transitioning from their own lived experience of MH difficulties to providing a service to support others with their MH difficulties?

When referring to this experience in the remainder of the thesis, it will be abbreviated to ‘the transition’ or ‘transitional experience’.

3.0 Methodology

The following section expands on the information provided in the journal article and provides a comprehensive overview of the methodology. I begin by providing my ontological, epistemological and researcher characteristics, which contribute to the rationale for qualitative research and Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). Critical appraisal of IPA will also be outlined and alternative methodologies considered. Delineation of the participants and the recruitment procedure will be offered and the data collection summarised. A detailed analysis process will be outlined, including adherence to quality assurance. Finally ethical considerations will be addressed.

3.1 Study rationale

Ontological, epistemological position and researcher characteristics

Ontology considers the nature of human beings and reality. I see reality as having an objective existence, independent of our knowledges, which are subjective but also interwoven with the world and underlying conflictual structures (for example; social, political, cultural, economical, ethical, gender). All experience is fallible and theory-laden (Sayer, 1992). Although I believe an underlying reality exists, I feel that there are multiple perspectives of this reality and therefore it cannot be directly accessed.

Epistemology can be interpreted as a method of analysing the way human beings grasp knowledge about what is (perceived to be) existing (Pfeiffer & Niehaves, 2005). When considering my epistemological stance on knowledge, I would position myself towards a relativist stance with meaning and nature of knowledge being dependent upon our view of it. As a researcher, I can never experience this reality directly, only various co-constructed versions of it, for example, by using double hermeneutics, which refers to the researcher trying to make sense of the participant attempting to make sense of their experiences (Smith, Flowers & Larkin, 2009).

My personal and professional experiences and orientations have relevance to each stage of the project from conception to write up. I am a trainee clinical psychologist whose work is informed by an integrative approach. In my clinical practice my work is based on the core principles of a critical realist epistemological position (Bhaskar, 1989). Essentially, I believe past experiences influence our behaviours and thought regardless of any endeavours to 'bracket' (Kvale, 1996) these experiences. Bracketing is the ability to suspend or put to one side any prior knowledge, assumptions or preconceptions. As a researcher, my epistemological stance provides me with the guiding principles upon which I may base my methodologies (Guba & Lincoln, 1994). They affect my research process in that they permit me to develop questions, design the study and adopt appropriate research strategies. In conclusion, I would place emphasis on inductive research, advocating that observations are not easily reduced to numeric form. That is not to say that I refute quantitative research. On the contrary, I feel both qualitative and quantitative methods could, rather than seen as opposing views, be used in conjunction to enrich and direct each other. Furthermore, when reporting my findings I quantified my observations. This was not to suggest that prevalence equated salience but was used in order to provide the reader with a clear indication of how pervasive findings were within the sample. I felt using exact numbers rather than general descriptors (i.e. all, some, most) helped to achieve this aim.

Considering the current study, a critical realist position purports that an event can be experienced differently by the researcher and participant and is dependent on individual "thoughts, beliefs, expectations and judgments" (Willig, 2008, p. 70). Attempts to access the participants' experience are initially reliant on the participants' abilities to be able to and willing to disclose these experiences and secondly dependent on my personal life experiences (Bhaskar, 1989). Although I have no personal experience of being an employed MH PSW, I am acutely aware that my experiences and personality have inevitably influenced my opinions about PS. For example, in my clinical practice I have experienced the positive impact of service user involvement and although I have witnessed differing levels of involvement, genuine initiatives that support participation have secured a more patient-led service that, for me, better addresses the needs of the consumers. Subsequently, I have advocated for better service user involvement. I feel

partnership working is fundamental and a breakdown of traditional ways of working is needed, particularly in relation to a medicalised approach which often pathologises the individual without consideration of social disadvantage. Therefore, it is unsurprising that I was attracted to this area of research and have a genuine interest in the practice of PS. However, I entered the PS field of research unconvinced by the theoretical underpinnings of PS and felt there was a lack of empirical evidence supporting some of the claims. Being aware of my potential personal influences on the research has supported the reflexive component of this research.

Rationale for qualitative methodology

The purpose of this research was to explore a PSWs transitional experience. In view of the limited research base in this area, I wanted to employ a methodology which would develop the understanding of this experience. Qualitative methodology is particularly relevant when attempting to uncover patterns of meaning, interpretation and understanding and when exploring psychological phenomenon that has not previously been researched in detail (Turpin et al., 1997).

Previous research on PSWs has almost exclusively been conducted outside the UK and has invariably been part of a service evaluation (e.g. Hutchinson et al., 2006; Salzer & Katz, 2009) with limited in-depth analysis, capturing the depth of participants' sense making of their experience. Furthermore, the studies that have described the role of PS (e.g. Richard et al., 2009; Moll et al., 2009) have used an interview schedule that has directly mapped onto their key themes, whilst failing to offer an understanding of the researcher's subjective analysis and interpretations. Other studies (e.g. Mowbray et al., 1998) incorporated participants from a number of PS services and were not individual interviews, therefore limiting the ability to access a deeper understanding of an individual's experience and offering less homogeneity within the sample.

Understanding the descriptive and interpretative accounts of the PSW in order to expand on a deeper understanding of this complex experience was imperative

and quantitative methodology was felt to be inconsistent with the aim of the current research, therefore a qualitative approach was selected.

Rationale for IPA

Corresponding to the research philosophy and theoretical framework, a meaning-focused research design, which enabled me to better understand the first person perspective through inter-subjective inquiry and analysis, was considered. IPA was chosen on the basis of it being rooted in both hermeneutics and phenomenology; providing the opportunity to explore the range, depth and complexity of a PSW's perspective, whilst also accommodating my critical realist positioning. IPA recognises that although understanding can be gained through the subjective experience, the process of acquiring this perception is dependent on the interaction between participant and researcher and unavoidably brings in the latter's perspective (Willig, 2008). Although IPA has a relatively short history (first published article in 1996), it is closely affiliated with psychological research and often has an explicit aim of offering insights into clinical practice, comparable to the current research aims. Furthermore, studies outside the PS literature have explored transitions (Meek, 2007; Millward, 2006; Roncaglia, 2006) and new role enactments (Seamark & Lings, 2004) using an IPA approach, suggesting that the methodology is compatible with the phenomena I wanted to explore.

Phenomenology

Phenomenology was introduced by Edmund Husserl in the early years of the 20th century (Giorgi & Giorgi, 2008). Phenomenology is the philosophical method to the inquiry of experience and is essentially concerned with the experience of 'being' and what that resembles (Smith et al., 2009). In particular, IPA explores an individual's beliefs about a phenomenon and the meaning of the lived experience to them as an individual, whilst simultaneously endeavouring to understand the essence and complexity of that account (Smith et al., 2009). IPA utilises aspects of Husserlian phenomenology, particularly his endeavours to go "back to the things themselves" (Husserl, 1913/1982, p.35). This enables "experience to be expressed in its own terms" as opposed to trying to

accommodate experience into prefixed categories (Smith et al., 2009, p.32). Husserl further promoted the use of bracketing in order to reach the essence of a phenomenon, thus to accept something because of the way it first appears, rather than what the observer thinks they already know about it. In contrast, IPA argues that it is unfeasible to bracket a researchers preconceptions and their insight of the world will impact upon the research process (Willig, 2008).

This approach complemented the exploratory aims of the current research and accommodated my epistemological positioning. Essentially I was attempting to understand the instances when employed PSWs were momentarily aware of their transitioning experiences into the PS role, rather than absorbed in the daily flow of life (Smith et al., 2009).

Hermeneutics

Hermeneutics is the theory of interpretation. IPA asserts that the researcher is an active contributor when understanding the participant's interpretation of their experience (Smith et al., 2009). The double hermeneutic stance of IPA is suited to this current research because it acknowledges that previous understanding and experience will invariably impact on both participants and myself in relation to the dynamics of the interview process itself, what the participant speaks about and how they chose to express this and how I analyse and interpret the data. The double hermeneutic positioning draws upon Heidegger's hermeneutic phenomenology, which criticised Husserl's theories for being too abstract and bracketing being unobtainable (Heidegger, 1923). Phenomenology for Heidegger is not a descriptive, disconnected analysis of consciousness but a method of access to being, whereby the researcher is 'involved in' rather than merely objective. Heidegger's conception of being-in-the-world precedes the bifurcation of subject and object which he argued created abstract and fixed constructions (Hatab, 2000).

Critique of IPA

Using a systematic literature review, Brocki and Wearden (2006) provided a critical evaluation of the use of IPA. They reported that the lack of clarity surrounding

interpretation may cause variations in the amount, quality and depth of information provided. Furthermore, it has been reported that novice researchers have a tendency to produce rudimentary findings rather than in-depth analysis (Smith, 2004). Despite these shortcomings, I felt that IPA was the most appropriate methodology for my research aims.

Additionally, within IPA, the respondent is required to express their thoughts and experiences sufficiently so that an interpretation can then be made, which may not be always possible. However, use of probes and prompts may disperse some of these concerns. Smith and Osborn (2008) argue that a participant's emotional state can be interpreted by the researcher, whereby they analyse what is said in addition to what is not said. This research endeavoured to adhere to these principles. Further consideration of non-verbal cues, metaphors and emotions during the interviews provided additional forms of communication of the individuals' experience.

A further critical appraisal of the IPA approach is offered by Giorgi (2010/2011) who argues that its modification of phenomenology to fit the IPA method has resulted in a distortion that is not consistent with a phenomenological perspective or worthy scientific practices. He argues that the approach is methodologically unclear and often neglectful of good scientific rigor. A fundamental problem of phenomenological research is "the fact that the scientific practices and procedures of a science based upon phenomenology are not yet systemized or securely established...concrete procedures acceptable to all sympathetic researchers does not yet exist" (Giorgi, 2010, p. 4). In response to Giorgi's concerns, Smith (2010) resolutely offered clarity around the IPA methodology and argued Giorgi's queries signified a limited and incomplete understanding of IPA. However, retorting Smith's rebuttal, Giorgi (2011) has detailed flaws in Smith's fortified responses and argues there is a persistent superficiality to IPA's phenomenological and hermeneutic foundations.

Giorgi and Giorgi (2008) have developed a more traditional normative and scientific framework to better understand the nature of the phenomenon being explored (Finlay, 2009). However, different qualitative approaches have borrowed and

cultivated phenomenological philosophy and techniques, applying variable versions of phenomenology (Finlay, 2009). I feel it is important to provide justified and consistent claims about the applied method and engage in 'phenomenologically based empirical work', rather than being interlocked in an on-going philosophical reflection 'on things in their appearing in the philosophical sense' (Finlay, 2009, p.3). Despite the shortcomings, IPA offers consistent claims about the methodology, linking explicitly and reflexively back to its' philosophical commitments, whilst providing phenomenologically based empirical work. I further feel that employing both general qualitative (Yardley, 2000) and IPA-specific (Smith, 2011) guidelines will better ensure rigour in my research and establish a quality control framework, though I acknowledge problems exist with the scientific practices of IPA.

3.2 Different Qualitative methods

The following section outlines alternative modes of enquiry, though not exhaustive, and considers their appropriateness to the aims of the study, whilst further developing a coherent argument as to why I selected IPA.

Grounded theory (GT)

GT is intended to systematically facilitate the process of theory generation through the application of saturating the data through a number of analytical constructs (Willig, 2008). Although Dey (1999) suggests that theoretical sufficiency is satisfactory, acknowledging the data sources are not completely exhausted. While individual experiences are explored in GT, the current research was concerned with exploring the lived experience of the PSWs and not theory generation on transitions and role enactment. Furthermore, as a researcher I am unconvinced that saturation of the data is viable. I agree with scholars who have argued that the concept of saturation is inappropriate (Dey, 1999; Strauss & Corbin 1998). Researchers often close categories prematurely (Dey, 1999) or more extensive examination and analysis of data will always provide the potential for the 'new to emerge' (Strauss & Corbin, 1990, p.136).

Finally, modernist GT generally subscribes to the act of researchers being able to 'bracket' their own views and preserve objective examination when comparing data sets (Strauss & Corbin, 1990), although Charmaz (2006) offers a more interpretative process through constructivist GT and positions the researcher as co-producer. Given my epistemological positioning I feel it is impossible to free oneself of preconceptions in the data process and therefore consider modernist GT to be incompatible with my critical realist perspective and the research aims. A constructivist positioning is also incompatible with my understanding of knowledge and reality because it denies the existence of an objective reality, "asserting instead that realities are social constructions of the mind, and that there exist as many such constructions as there are individuals" (Guba & Lincoln, 1989, p. 43). Although I follow a critical realist perspective and dispute certain default assumptions of empiricism and realism, I nevertheless subscribe to the notion that the inherent order of things is 'mind-independent' (Tsang & Kwan, 1999, p.761), whereas constructivists accredit structures 'not to a mind-independent reality, but rather to the generative (and therefore constructive) act of researchers and theorists' (Kwan & Tsang, 2001, p.1169), therefore incorporating a different set of implications for strategy research.

Thematic analysis (TA)

TA identifies patterns or themes from participant data and offers the researcher with clear guidelines in analysing the material (Braun & Clarke, 2006). It promotes a flexible approach and can incorporate a detailed description of the data set or a comprehensive account of a particular aspect (Braun & Clarke, 2006). TA can remain at a descriptive and explicit level with the themes (semantic) or move towards interpretation (latent). Additionally, it advocates both an inductive and theoretical approach whereby coding for a particular research question can occur or a research question develops from the coding (Braun & Clarke, 2006). This approach could be considered to be appropriate to the research, particularly if I applied thematic analysis at an inductive and latent level. Applying this particular type of TA is arguably similar to IPA, though unlike IPA, it is not grounded in a particular theoretical underpinning (Braun & Clark, 2006). Additionally the approach is compatible with my ontological and epistemological positioning. Subsequently, the rationale for not using TA became

less about the lack of appropriateness and more about why IPA was suitable. IPA was considered to be central for understanding the meaning of lived experiences of PSWs because of its phenomenological and hermeneutic origins. Although TA, like other modes of enquiry, recognises the influential position of the researcher, it is not a prominent feature. IPA explicitly addresses the double hermeneutics between researchers and participants. Additionally, the hermeneutic circle is emphasised throughout the research process. This was felt to be better suited to my ontological and epistemological understandings.

Discourse analysis (DA)

Potter and Wetherell (1987) locate meaning in the social world and assert that exploring the language and discourse are the means by which a researcher can access an individual's version of the world, society, events and psyche which are all context-dependent behaviours that are not fixed but ever changing (Hollway, Lucey & Phoenix, 2007). Over the years, DA has been embraced by a number of social science disciplines and currently offers a number of different strands, though all attain a comparable interest in the role of language and the construction of social realities (Willig, 2008). DA considers the interconnected relationship between researcher and participant (Potter & Wetherell, 1987) thus accommodating my critical realist perspective. The aim of the current research was to explore the meaning and sense-making of the transitional experiences for PSWs, rather than relying exclusively on linguistic resources to convey a message within a given context. Although part of the analysis process in IPA is to comment upon the linguistic properties of the transcript, it forms part of a much broader objective. IPA enabled me to explore the connection between the PSW experience, how it was discussed, was made sense of, and the emotional reactions to the experience (Smith, 2011). Finally, DA does not correspond with my epistemological understandings because it assumes a relativist ontology, believing there are multiple constructed realities.

Phenomenological Analysis

Currently, a debate persists between phenomenologists as to what comprises appropriate analytical methods in the practice of phenomenological practice (Finlay, 2009; Giorgi & Giorgi, 2008). However, the essential purpose of the analysis is to reduce lived experiences to its simple essentials and reveal the embodied or experiential meaning (Wertz, 2005). Again, this approach assumes bracketing is feasible and is therefore incompatible with my critical realist perspective. However, if taking a Heideggerian perspective, this would be consistent with my epistemological understanding. Again the issue becomes less about why a phenomenological analysis is not appropriate and more about why IPA is suitable. In addition to the above sections offering justifications for why IPA is an applicable methodology for answering my research questions, the use of practical and accessible guidelines within IPA was appealing, particularly as a novice researcher. The use of guidelines is largely absent, or continuingly debated as inappropriate, within the phenomenological field of research.

In conclusion, each qualitative methodology has strengths and limitations. IPA was selected over other qualitative methods because it was directed by my research question, literature review and epistemological stance. IPA offers a flexible approach and its interpretative range goes beyond description of themes exploring the nature of experience. Unlike grounded theory, it is informed by direct engagement with existing theoretical constructs and through double hermeneutics, recognises the researcher is subjectively embedded within the research. Braun and Clark (2006) recognised that “thematic analysis has limited interpretative power beyond mere description if it is not used within an existing theoretical framework that anchors the analytic claims that are made” (p.97). In contrast to discourse analysis, it goes further than the language and stresses the phenomenological importance and the individual’s experiential assertions and concerns (Larkin, Watts & Clifton, 2006). However, IPA is not without its criticisms and these will be acknowledged throughout the research project and discussed in more detail within the critical reflective section of the discussion.

3.3 Participants

Purposive sampling

The study used purposive sampling, (i.e. individuals likely to provide the research project with the most insight into a particular experience, in this case PSW experience, were approached to participate), consistent with an IPA approach which advocates the attempts to explore participants' perception of a specific experience (Smith et al., 2009). Purposive sampling enabled a better opportunity to locate convergence and divergence within the derived themes and increased theoretical understanding of these themes. Finally, the aim of the sample was to represent a perspective rather than a population (Smith et al., 2009).

Homogeneity

Homogenous sampling asserts that the essential characteristics of each participant are comparable. IPA endeavours to recruit a moderately homogenous sample who can meaningfully relate to the research question (Smith et al., 2009). In this research homogeneity was established through purposive sampling to ensure all participants were employed concurrently and were NHS MH PSWs within the same Trust. However, I am aware that to claim homogeneity within a sample can be credulous when many differences exist between participants and even more are unaccounted. Additionally, IPA pursues the idiosyncratic experience and accordingly each individual is considered in their own context, before convergence of the overall sample is examined. Finally, if I had attempted further homogeneity, there could have been a possibility that my foreordinations would have biased the selection process and inevitably the conclusions, thus diminishing the inductive practice of IPA.

Sample size

Although appearing rather arbitrary, Smith et al. (2009) suggest between four and ten interviews are appropriate, when considering sample sizes for a doctorate thesis. Novice researchers should aim for less to avoid being overwhelmed by the data (Smith, 2004). Furthermore, IPA necessitates a

rigorous qualitative analysis of detailed personal accounts provided by the participants and as such, IPA studies typically utilise small sample sizes (Smith, 2011). The application of a small sample size further encourages a robust idiographic commitment whereby a comprehensive and nuanced analysis of each transcript can be explored before cross-transcript analysis (Smith, 2004). Aligned with other IPA studies exploring transitions in organisational studies (Millward, 2006), I recruited seven participants.

Participant withdrawal

Participants were informed of their right to withdraw from the study and this was stipulated within the information packs, during the recruitment process, within the interview and after the interview. I felt that there was sufficient opportunity before the interview for participants to consider the research and withdraw after initially consenting. Further procedures were implemented to ensure individuals had read and understood the study aims before an interview (i.e. the information pack and discussing concerns and questions with the PS coordinator and myself). Withdrawing from the research during the interview was another safeguard. Participants were finally able to withdraw from the research at any time up to 48 hours after the interview. Allowing 48 hours 'cooling off' period was a final protection for the participant. Forty-eight hours allowed thinking time and reflection after the interview. It was felt that allowing participants to withdraw at any time was unrealistic (i.e. once the data was published, there would be limited control on recalling data from a public domain). It was outlined in the participant information sheet that if a participant decided to withdraw from the research after the interview, the data would not be used and there would be no repercussions. This was again reiterated at the interview stage. No participant withdrew from the study.

Inclusion and Exclusion Criteria

- To be included, individuals had to have had lived experience of MH difficulties and be currently employed as a PSW, providing PS to individuals with MH difficulties. Additionally, participants needed good comprehension of the English language so the researcher could conduct, interpret and analyse the interviews.

- Individuals who were employed within the PS service for more than 12 months were excluded. This was deemed to be necessary because it was believed over 12 months would hinder the ability to recall the transitional experience.

3.4 Participant recruitment

Procedure

Participant recruitment commenced following single site ethical approval (appendix J) research and development approval (appendix K) and university approval (appendix M) all obtained in September 2010. The study was given favourable opinion with a few amendments. Amendments included clarification over my attendance of a team meeting with the PS service and minor changes to the participant information sheet (appendix L).

Participants opted into the study once they received an information pack from the PS project coordinator on my behalf (see figure 4 for recruitment flow chart). Information packs were offered to all ten PSWs within the PS service. There are salient issues with PSWs being asked to participate in the study by their coordinator and the possibility that they may feel obligated to do so. A meeting was arranged with the project coordinator prior to her distributing the information packs. It was agreed that the project coordinator would reiterate that the research was independent to their roles and responsibilities as a PSW. The PS coordinator informed individuals of their right to not participate and withdraw from the research at any time if they chose to participate. Therefore any information gathered during the interview, or choosing not to take part would have no impact on the potential participant. Finally, the project coordinator highlighted that she was blind to the recruitment process and would not be privy to participant information. I also attended one team meeting to outline the research further and answer any questions and concerns. Again it was reiterated that there were no obligations to participate in the study.

Information packs

The information pack received by potential participants contained a cover letter, an information sheet, an expressed interest slip and a stamped addressed envelope (for cover letter, information sheet and expressed interest slip see appendix F, G & H). Potential participants were asked to contact me (via letter, email or telephone) if they had an expressed interest in the study and wanted more information or wanted to participate.

Due to the small number of potential participants available, potential participants who had not expressed an interest in the study following a two-week period were re-approached by the project coordinator with a follow-up reminder of the research (generic email sent to all PSWs). No further contact was made with the potential participant if they did not opt-in at this stage.

Receiving a completed participant's expression of interest slip, provided me with permission to contact the person using their preferred method, time and day and enabled a further discussion of the study and to address any additional questions or concerns. Verbal consent was obtained on the telephone from all eight participants. I asked each participant whether they wished the interview to be conducted at their home, workplace or another local NHS Trust location. I highlighted the need for the room to be quiet and private. All participants elected for their workplace within the community or the main building where the PS service was based. Subsequently, a convenient date and time was arranged for the interview to take place, whilst ensuring that at least 24 hours had lapsed between the individual giving verbal consent and the interview taking place. This was to warrant sufficient time to consider the study and to reflect upon whether to take part or not in the research. Participants were provided with contact details in the event that they wanted to withdraw from the study. Finally, I took responsibility for booking the meeting rooms for all the interviews. Following the recruitment procedure, I made telephone contact 24 hours prior to the interview to confirm the time and location of the appointment. One person did not continue to the interview stage for unknown reasons.

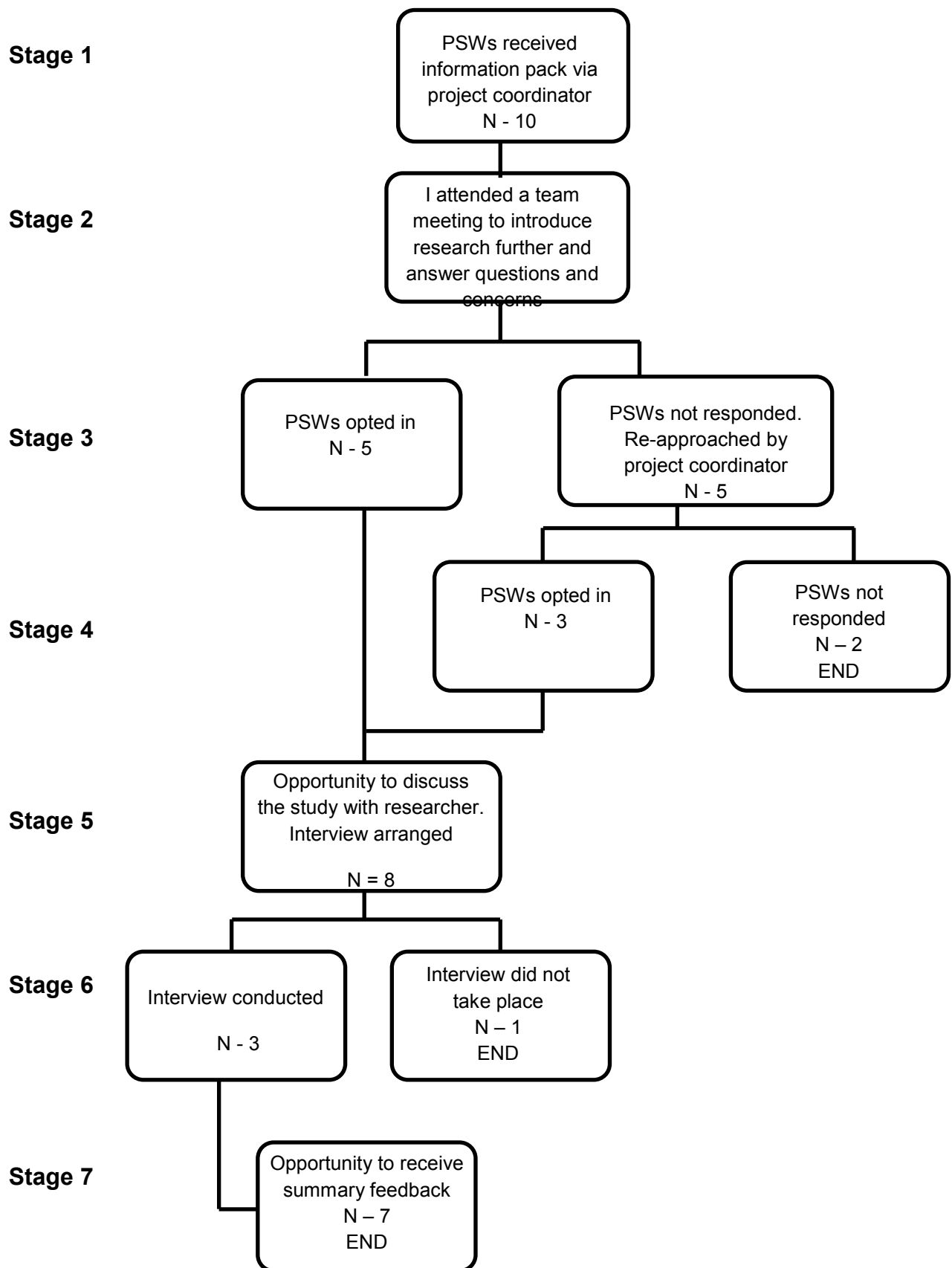


Figure 4. Recruitment flow-chart

3.5 Data collection

Rationale for a semi-structured interview and interview schedule

Although methods such as email correspondence are acceptable IPA approaches (Turner, Barlow & Ilbery, 2002), I felt a face-to-face situation was the most appropriate approach by which to interview the participants. I felt it supported a development of rapport building with participants and allowed me to observe non-verbal cues (e.g. intonation and body language) in order to help guide the interview and assist putting description into context during my analysis. Most IPA studies incorporate semi-structured individual interviews (Brocki & Wearden, 2006) although a focus group setting is suitable (Flowers, Duncan & Knussen, 2001). I decided against a focus group approach because I felt individual interviews were better assimilated with my epistemological positioning and would provide me with a richer opportunity to understand each participant's experience. Individual interviews can also provide a more open dialogue without the individual being unnecessarily influenced or restricted by the presence of other participants.

To help facilitate an interview, IPA recommends the application of a semi-structured interview schedule to guide the interview and allow the researcher to gain an in-depth personal account of the topic area whilst remaining flexible. In order to develop the interview schedule I followed an iterative process outlined by Smith et al. (2009). I initially referred to the existing literature on employed PSWs to appraise the current use of interview schedules whilst also considering areas neglected in the current research base. I held consultations with my clinical supervisor, field supervisor and members of the Trent DClinPsy service user and carer panel. Some of the panel members had experience of being service users and volunteering with services to offer informal PS. Following these discussions aspects of the interview schedule were redrafted, reduced and reworded. I had intended to pilot the interview schedule with a member of the service user and carer panel who had agreed to participate and a pilot interview was arranged. Unfortunately due to personal circumstances the volunteer had to cancel. Subsequently it was piloted with a colleague who was also a trainee

clinical psychologist. This process provided feedback regarding content and whether it achieved its intended aims. The approach to sensitive information and the language used was also appraised. Lastly the pilot interview was used to develop my interviewing skills.

The final interview schedule followed a chronological sequence to explore the transitional experience in its entirety. This enabled their current experiences to be placed in context and allowed participants to set the scene prior to discussing the transitional experience and enacting the PSW role. The interview schedule used open-ended questions to enable participants to reflect on a number of aspects of their experiences. The questions were non-directive and mostly open and expansive, incorporating descriptive, narrative, evaluative, circular and comparative questions (appendix Q). Prompts and probes were developed in advance to support the participant in elaborating further on their answers. The interview schedule was used, but not in a prescriptive manner. When tangents developed, I adopted a principle of open curiosity.

Interviews

On the interview day I followed an interview brief which ensured I outlined the plan for the interview with the participant and provided them with opportunities to ask questions. I outlined the time commitments and explained that although I had envisaged the interview would take approximately one hour it could be less or more dependent on what they wanted to bring to the interview. I delineated that an interview can sometimes feel like a one-sided conversation and I will probably say little and at times the questions may appear self-evident but it is about me getting to grips with how they understand things. I repeated that I was interested in what they have to say about topics and although I had several starter questions, they were seen as prompts only and I would be directed by them.

I spent time going through the consent form, explaining each section to participants and answering any questions before obtaining written consent. This was to ensure that all participants were properly informed about the research,

and questions were addressed (Strydom, 2002). During this stage the reasons for audio recording were restated. I further reiterated that names and identifiable data would be changed. I explained to each participant that they could stop the interview at any time for a break or if they wished to terminate and withdraw from the research. I further outlined that during the interview, they had the option of immediately removing something they have said from the transcript, if they wished. I felt that this was important because it provided the participant with more control and permitted a free-flowing conversation, without the constraints of filtering sense-making. However, I limited this option to interview stage only. I felt that if participants went away from the interview and then decided to delete or change elements of the transcript, this would contaminate the initial meaning they had attributed to the experience and also interfere with the double hermeneutics process.

All seven participants agreed to take part in the research and signed the consent form prior to commencing the interview. Three participants utilised the option of removing data during the interview. At the end of the interview copies of the information packs were provided to enable the participant to retain contact details, make further enquiries or complaints following the interview or if they wished to withdraw from the research. Participants also completed a demographic form to aid the interpretation of the data and provide a context for the analysis. However, I explained to the participants that they had the option of not disclosing this.

At the end of the interview, participants were offered a £10 high street voucher for taking part in the interview. There are salient issues relating to paying participants which can raise ethical issues and impact on the research process, such as coercion, relationship between the participant and research and interfering with an individual's social security benefits. To limit the issues outlined above, I explained in the participation information sheet and before the interview that I was interested in hearing about their opinions and experiences of their transition and there were no right or wrong answers. It is felt that this one-off gift was in line with the Reward and Recognition guide (DoH, 2006) and aligned with the spirit of service user involvement and the research itself. All participants accepted the vouchers.

Each participant was also provided with a debrief following the interview and offered a debrief summary (appendix P). This outlined my thanks for their invaluable time and input and my hopes that it was a positive experience both with sharing their story and the potential contribution it will make towards the PS research. I also highlighted the available options (i.e. follow up interview) should they experience distress following the interview and their right to withdraw from the research 48 hours after the interview. Finally participants were provided with the opportunity of receiving a study summary or full report of the research (appendix O).

3.6 Analysis process

The overall purpose of the analysis is to make sense of the individual's experience and "the meanings, particular experiences, events, states hold for the participants" (Smith & Osborn, 2008, p.53). There is no single approved method for analysing data with IPA and subsequently different authors have applied slightly different processes (Smith et al., 2009). This is unsurprising considering Smith's (2004) cautionary stance that "one cannot do good qualitative research following a cookbook" (p.40). As a novice to IPA I broadly adhered to Smith et al., (2009) stages of analysis, described below. However, when reflecting upon my affiliation to these guidelines I agreed with the deliberations offered by Gee (2011) who described a 'road-map' analogy. Essentially, I used the stages to map out a skeleton route of the analysis and worked intuitively through my data with reference back to the stages to ensure my analysis had gone in the right direction and I had not gone off track. This enabled me to consider the method as flexible, rather than prescriptive and that there were also different routes in order to achieve the same goal.

The analysis of data took an idiographic and iterative approach, beginning with particular examples and slowly working towards a more general categorisation or theory (Smith, 1996). Each transcript was analysed consecutively with the purpose of progressing from the individual account to the shared account and shifting from the descriptive to the interpretative (Smith et al., 2009). Typically this process

ensured a cyclical relationship with myself and the data as I alternated between the individual's descriptive account to my own interpretation back to the individuals descriptive account (Smith et al., 2009) and then repeated the process with all transcripts.

Whilst analysing each transcript, I was conscious of the themes I was deriving from the data. I was mindful of convergence and divergence and being open to novel themes within individual transcripts and across all seven transcripts. Additionally, whilst engaging with the data my psychological knowledge was applied to interpret what the experiences meant for each participant. Whilst undergoing this process I actively maintained an audit trail to track my interpretations and ensure I was remaining close to the data (See appendix R to follow the stages of analysis with additional reflective diary extracts for one participant, 'Scarlet'). The stages of analysis are described in more detail below.

Step one: Reading and re-reading

Firstly, I listened carefully to the recording without interruption. This allowed me to capture the 'tone' for each interview prior to transcription. Secondly, I transcribed each interview verbatim, with considerable margins either side for later note-taking. It took approximately one hour to transcribe ten minutes of interview. Whilst transcribing each interview I changed identifiable information and used codes to depict non-verbal actions such as pauses and higher volume of speech. Numerical coding was also inserted beside the sentences within the transcript to facilitate the identification of an extract. Following the transcription I repeatedly re-read the transcripts in order to familiarise myself with the data. The attention at this stage was the descriptive account of the transitioning experience offered by each participant. During this step I made separate notes on my thoughts, observations and reflections that transpired whilst reading the text and also any recollections that I had about the interview itself. This helped me to isolate some of the initial overwhelming ideas and possible connections I had and instead redirect my attention to the data (Smith et al., 2009). This process also allowed me to surpass the sequential account offered by the participant as a consequence of the interview schedule and

benefit from a more complete sense of the transcript. In particular it permitted an understanding of narratives attaching certain fragments of the interview together and situated the comprehensive data, the less detailed data, the contradictions and paradoxes (Smith et al., 2009).

Step two: Initial noting

Initial noting was the most detailed and laborious process of the entire analysis and incorporated overlaps with the previous step. Although this step encouraged free textual reading, I was directed by the three levels of analysis outlined by Smith et al. (2009) which incorporated descriptive, linguistic and conceptual reading.

The descriptive comments focused on key words, phrases or explanations which the participant used. This level relied on accepting the participant's accounts exactly as they appeared in the transcript. The core essence of the linguistic comments was the language use and how participants used this to frame meaning and content. The focus of my linguistic comments and noting para-linguistic features, mainly attended to pronoun use, pauses, hesitation laughter, repetition, tone and fluency level. Metaphors, similes and analogies were also recorded. The third level of conceptual comments was interpretative and enabled me to be much more interrogative about the data. There was also an aspect of personal reflection whereby I inevitably elicited my own experiential and professional knowledge. Corresponding to a critical realist epistemological positioning this process was unavoidable and was used to extend my engagement with the data and explore further elucidations. The development of initial noting was complete when the transcript had come to an end (see appendix R(A) for a transcript extract with notations).

Step three: Developing themes

At this step, the analysis was twofold, I had to simultaneously condense the sizeable data whilst sustaining the complexity of the data in relation to the “interrelationships, connections and patterns between the exploratory notes” (Smith et al., 2009, p. 91). To develop initial themes I studied the transcript and exploratory comments collectively, the left hand column of the transcript was used to denote these initial themes (see appendix R(B) for extract example). This stage involved collapsing the narrative flow of the interview and subsequently I played a more pivotal role in the sense of organising and structuring the data. I began to place interpretations on the data and moved further from the participants account but remained faithful to it. Supervision was particularly important at this stage to ensure that my rationale behind the initial themes were justified and could be accurately traced back to the raw data. Essentially, the end of this stage resulted in exploratory notes being condensed into concise themes representing the essence of the data.

Step four: Part 1: Connecting the themes

At this level the aim was to map out how I thought the initial themes interconnected and follow a structure which enabled me to capture the most interesting and prevailing aspects of my participant’s account. Exploration and innovation is encouraged at this level and emphasis placed on it not being prescriptive (Smith et al., 2009).

Firstly, I attempted to arrange the initial themes into chronological order, particularly because the semi-structured interview had been framed that way. However, this was not a fruitful exercise and to cluster themes which represented parallel or similar understandings worked more effectively. To reduce the themes, prior to considering the interconnectedness, a numeration table was developed. (see appendix R(C) for example). The frequency did not denote theme importance but was used practically to conceptualise identified themes and to highlight how relevant it was for the participant (Smith et al., 2009). Within the numeration table, I listed the themes in alphabetical order; this enabled me to establish similar themes that could be collapsed or removed.

Themes removed were placed into a table of removed themes, accompanied by a reason outlining why I felt they should not be included.

Once I was able to reduce the themes through the numeration table, I focused on identifying patterns between the initial themes and clustering similar themes to create subordinate groupings. A further abstraction was considered when subordinate themes were subsumed into superordinate groupings in order to combine a succession of distinctly related subordinate themes. Themes were also examined for oppositional relationships and were often polarised into positive and negative experiences and well-defined and uncertain accounts. A final consideration of the initial themes was contextualisation and attending to key experiences peppered in the participants' narratives.

Following the establishment of patterns and connections between the initial themes, they were represented in a table (see appendix R(C): step 4 for example). Subsequently, this developed into a more comprehensive table incorporating the superordinate theme, subordinate theme, quotes representing the theme and page and line number where it could be located in the data. This graphic representation of the structure of the themes provided me with the opportunity to ensure my interpretations were coherently related to the raw data. This was possible because the table provided me with the essence of the transcription in its complete form and clearly delineated the relationship between the raw data and the superordinate themes.

During this process, I utilised my reflective diary, in order to make certain that the interpretation process was appropriately documented and could assist me in reflecting upon my decision-making when retaining or discarding themes. This was also supported by the removed themes table.

Step four: Part 2: Moving on

This step involved progressing to the next participant's transcript. Although I was aware of, and undoubtedly influenced by the previous themes formed from the patterns and connections within that transcript, it was important for me to approach the next account with openness. In order to achieve this I allowed new

themes to develop with each transcript. I found my reflective diary supported this process. Additionally, I noted when I believed I was being influenced by previous transcripts and felt documenting this enabled me to return to these reflections at a later point when completing cross-transcript analysis. Fortunately, this process was eased with the diverse characteristics of all the participants. Although I also found it useful to leave space between the transcripts and approach each account with refreshed and recharged attention.

Step five. Patterns across transcripts

The final stage of analysis involved establishing patterns across the participants' accounts. Smith et al. (2009) advocate a questioning process to support the simultaneous examination of the tabulated themes of all participants (i.e. how does a theme in one account help illuminate a different account?). Essentially this process produced a reorganisation of the themes with reconfiguration and relabeling according to their content, potency and similarities. Finally, I identified the recurrent themes within the sample (see appendix R(D) for an example). Smith et al. (2009) recommend the usefulness of this with working with a larger number of participants. However, numeration did not dominate my analysis but informed it by depicting themes which prevailed in more than half of the participants.

Again supervision was particularly important at this stage to ensure that my rationale behind my subordinate and superordinate themes were justified and could be accurately traced back to the raw data. Analysis and interpretation continued when writing up the analysis and results section because it provided me with the freedom of moving back and forth between the stages and developed my understanding of the relationships between themes.

3.7 Quality assurance methods

Audit trail

Committed to the endeavours of qualitative investigation I sought to substantiate quality by ascertaining 'trustworthiness' of the findings (Lincoln & Guba, 1985). I kept an audit trail delineating a transparent and explicit process of my decision-making throughout the analysis. This permitted the tracking of my interpretations to be traced back to the participant's accounts (Smith et al., 2009). The write up of the thesis was another method of demonstrating transparency (Smith et al., 2009) and provides the reader with a translucent account of the participants, the selection procedure, the development of the semi-structured interview schedule, the interview procedure and the process of analysis (Smith et al., 2009).

When assessing the specific quality and validity of IPA papers, Smith (2011) has developed a criterion exclusive to IPA which was particularly important to consider when writing my journal paper. However, I was also mindful of the problematic disposition of checklists. No approach can completely suspend biases in judgement and appraisal tools are often either unmeasured or quite variable (Dixon-Woods et al., 2007; Lohr & Carey, 2009). Furthermore, Smith's (2011) guidelines were particularly subjective and could be interpreted in a number of ways. Nevertheless, the evaluation guide was utilised in an attempt to produce a good IPA paper. Essentially I ensured the journal article subscribed to the theoretical principles of IPA, that the analysis was sufficiently transparent and plausible and incorporated enough sampling from corpus to demonstrate the depth of evidence for each theme. Additionally I endeavoured to meet the criteria in relation to producing a well focused study with robust data and interpretation in order to engage the reader with an informative paper.

Member checking

Member checking seeks feedback from the participant following the interview, usually to check the initial conversation was captured accurately, or when analysis has been completed and to check meaning (Lincoln & Guba, 1985). The aim is to improve accuracy and validity after the participant feedbacks whether the findings reflected their views, feelings and experiences. This study did not incorporate member checking because it relies on the assumption that there is a fixed truth of

reality that can be accounted for by a researcher and confirmed by a respondent. Following the principles of IPA, what the participant might have said at the time of the interview is subject to change, therefore member checking would be a redundant tool. Instead, I included primary data depicting how I had reached my findings and kept an audit trail to delineate clear, transparent and reflective descriptions of the research process.

Triangulation

Triangulation is often used as cross verification from more than two sources (O'Donoghue & Punch, 2003). The purpose is to confirm that different methods lead to the same results and thus enhances confidence in the findings. This can be achieved through methods, perspectives, data collection and analysis. It is necessary for methods of data collection and analysis in triangulation to be compatible with the research question and epistemology, if not, it would be difficult to generate meaningful insights and would provide different conceptualisations (Willig, 2008). Triangulation suggests there can be a single, definitive account of realism and knowledge. I consider there to be multiple perspectives of reality at any given time, therefore the current study did not purpose to find a 'truth'. Secondly, this 'truth' works on the assumption that data originating from different research methods incorporates unambiguous comparisons and can be viewed as equivalent in their functions of addressing the research question (Bryman, 2003), which I feel is unachievable. Finally, I feel triangulation would be inserting an additional level of interpretation (e.g. from another researcher) which is unsuited to the double hermeneutic fundamental to the IPA process. Subsequently, for these reasons, I did not employ triangulation in the current study.

Supervision

Regular supervision occurred throughout my analysis so I could check the plausibility of my interpretations (Smith et al., 2009). My research supervisor additionally analysed excerpts of a transcript. However, I was mindful that the process was to develop my analytical skills and to ensure my coding and interpretations had not been over-represented. Supervision was not intended to

seek convergence of interpretation because truthfulness and impartiality were not the focus.

I also participated in a peer support IPA group, set up with other trainees in my cohort. The trainees read excerpts of my transcript with completed note taking and considered whether they could track and understand the derived themes from the data set. Again this supported my audit trail but was not implemented as a means of triangulating my data.

Reflexive diary

Researcher bias has been highlighted as a potential problem that can impact negatively on the trustworthiness of the findings (Madill, Jordan & Shirley, 2000). The reflective diary was drawn upon throughout the project from conception to write up. The purpose of the reflections was to not only inform my analysis but to offer another layer of transparency (Yardley, 2000).

The use of my reflective diary was particularly evident at the interview stage and I made notes immediately after every interview in order to capture the short-lived knowledge of that experience. From a critical realist position I was conscious that at a different time and different context the same participant may have provided a different account of their experience and I may have interpreted the data in a different way (Bhaskar, 1989). Accordingly, once I departed from the interview I detailed my experience of the interview, overall thoughts, my impressions of the participant, what feelings had been evoked before, during and after the interview both for myself and the participant and what stood out for me. Another example of abundant use of my reflective diary was throughout my data analysis. The entries detailed my decisions concerning the removal of themes, the inclusion of themes and the justification for reorganising and reconfiguring themes.

3.8 Ethical Considerations

Risk of harm

I considered the potential risks of individuals participating in my research and the appropriate steps to minimise these. There was the possibility for the interviews to provoke sensitive and emotive conversations, leading to distress. Prior to the interview, participants were familiar with the information sheet which highlighted the potential risk of distress. During the interviews, I was sensitive to the participants' needs and there was always the option to have a break or terminate the interview. When debriefing, there was the opportunity to discuss the interview and its content. Following the interviews, there was not a need to advise any participant to contact their General Practitioner or any other relevant agency. No participant took part in the one off follow-up session with a Consultant Clinical Psychologist to discuss feelings from the interview.

There were no direct benefits to taking part in the research. However, participating in the interview may have provided validation for the participant with the opportunity to discuss their experience with an individual outside of their social environment. Furthermore, the research will hopefully contribute to the literature surrounding intentional PS and the participants sharing their experience could benefit future individuals encountering a similar situation. These potential benefits were supported by comments made by participants at the end of the interview. All participants detailed either their enjoyment of the interview or how they felt it may contribute to the PS literature and support future PSWs.

When considering risk to myself, the 'Lone worker' policy of the University of Nottingham and the local NHS Trust was adhered to throughout the interviewing process. A 'buddy system' was incorporated whereby I informed a colleague of my whereabouts both prior to and after each interview.

Informed consent

Prior to arranging an interview, participants were given the opportunity to discuss the study with myself or the project coordinator. Details were also provided in the information sheet for potential participants to discuss research generally with an

independent body. I outlined that the research would be submitted for marking by the university and potentially published. I emphasised to participants that every effort would be made to protect their anonymity. The opportunity to ask questions and the option to withdraw from the study was re-emphasised on the day of the interview and prior to the consent taking process. When participants completed the consent form (appendix N) I assumed that they all had capacity to consent as there was no evidence to suggest otherwise (Mental Capacity Act, 2005).

Confidentiality, anonymity and information storage

Every attempt was made to follow the 'Caldicott Principles' (NHS Executive, 1997) and to meet the requirements of the data protection act. The NHS code of confidentiality was followed and the British Psychological Society (BPS) Guidelines for minimum standards of ethical approval in psychological research.

Once the interview was completed audio data was transferred to computers at the University of Lincoln and encrypted. During transcription I replaced names and places with pseudonyms to ensure that participant identification was not possible. Any further identifiable information was removed from the transcript. I was the only person to have access to the raw interview data. Once transcription was complete, the audio data was transferred to individual Compact Discs (CD). This was labelled with an assigned interview code and data deleted from the University of Lincoln computers. Demographic information sheets and interview transcripts were also labelled with an interview code. All non-identifiable data was then stored in a locked filing cabinet at the University of Lincoln. Identifiable data including a sheet matching the transcripts to the participant's identities was kept in a separate locked filing cabinet at the University of Lincoln. All data will be stored for a period of seven years at the University of Lincoln in accordance with the code of conduct.

4.0 Extended Results

This section provides a more comprehensive exploration of the themes identified in the current research and described in the journal paper. Further details of subordinate themes will be introduced, interpretations outlined and though not exhaustive, exemplar quotes offered.

The following diverging radial and Venn diagram (figure 5) illustrates how the identified themes can overlap and impact upon each other for a given person. Although the themes were not arranged in chronological order, participants often made sense of their transitional experience by drawing on the past (entering the role and expectations), present (during the role) or future (aspirations and exiting the role). However, the diagram does not capture the fluid nature of the themes and that at any given time, and within particular contexts, one theme may be more pertinent than others and was not necessarily time dependent. The composition structure of IPA themes (including ordinate themes) is also displayed in table 3.

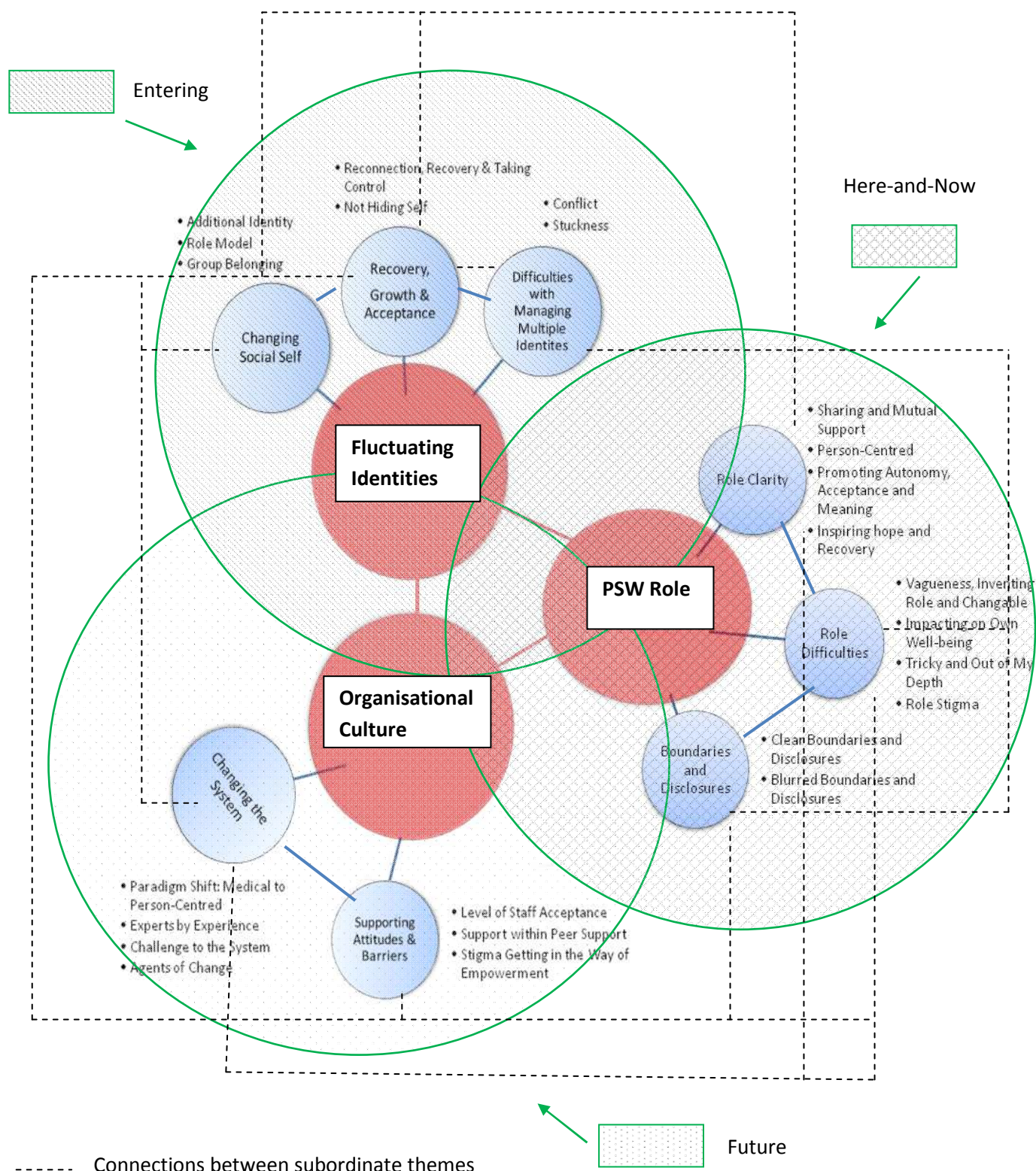


Figure 3: Diverging radial and Venn diagram illustrating the relationship between identified themes

Table 5

Composition structure of IPA themes (including subordinate theme)

Superordinate themes	Subordinate themes	Ordinate themes
1. Fluctuating Identities	1.1. Changing Social Self	1.1.1. Additional Identity 1.1.2. Role model 1.1.3. Group Belonging
	1.2. Recovery, growth and acceptance	1.2.1. Reconnecting, recovering and taking control 1.2.2. Not hiding self
	1.3. Difficulties managing multiple identities	1.3.1 Conflict 1.3.2 Stuckness
2. PSW Role	2.1. Role Clarity	2.1.1. Sharing and mutual support 2.1.2. Person-centred 2.1.3. Promoting autonomy, acceptance and meaning 2.1.4. Inspiring hope and recovery
	2.2. Role vagueness and difficulties	2.2.1. Vagueness, inventing role and changeable 2.2.2. Impacting on own well-being 2.2.3. Tricky and out of my depth 2.2.4. Role stigma
	2.3. Boundaries and disclosures	2.3.1. Clear boundaries and disclosures 2.3.2. Blurred boundaries and disclosures
3. Organisational Culture	3.1. Changing the system	3.1.1. Paradigm shift: from medical to person-centred 3.1.2. Experts by experience 3.1.3. Challenge to the system 3.1.4. Agents of change
	3.2. Supporting attitudes and barriers	3.2.1. Level of staff acceptance 3.2.2. Support within peer support 3.2.3. Stigma getting in the way of empowerment

The current research identified how participants engaged in a process of making sense of their experiences. This complements the phenomenological perspective that individuals embody an inherent capacity to assemble meaning out of experiences (Spinelli, 1989) and is captured in the following three superordinate themes along with my interpretations:

4.1 Fluctuating Identities

This superordinate theme incorporated participants' sense-making regarding views of self and what they had expected upon entering the role. This was broadly encapsulated under the subordinate theme titles: 'changing social self' and 'recovery, growth and acceptance'. The impact on self was an important construct for all the participants in this study when detailing their transitional journey.

4.1.1 Changing social self

When considering the transitional experience, all participants detailed a changing social self; whether this was framed within an 'additional identity', viewing themselves as a 'role model' or experiencing a form of 'group belonging'.

Scarlet's quote indicates her initial sense making of her experience whereby she explained it feels as though she is:

...going through the transition from being an end user to sort of the provider

From Scarlet's quote I have interpreted that this transition marked the end of one identity and the beginning of another for her, with two very distinct roles. Scarlet adds caution to her statement, perhaps hesitation or uncertainty, when she prefixes provider with 'sort of'. This may represent the unpredictable nature of her new identity or her reluctance at completely leaving the service user identity. There are further complexities associated with Scarlet's position in relation to a tri-part role. When she first entered the job, Scarlet requested a post within the team she had received her MH care from and, for the initial period of employment, continued to receive her care from. Subsequently, Scarlet has feasibly contended with the role of 'professional service provider', 'professional team member' and 'current service user'. Scarlet's use of 'sort of' perhaps captures the ambiguity of the identities, particularly given her novel situation. For Lucy she was more assured with the changes she was experiencing and detailed how she felt an almost enlightening transformation within herself:

I'm changing as a person, as I do this job...I'm just learning so much and listening to so many people's different opinions that it sparks so much thought (..) that it's hard not to feel like it's ground breaking really, my mind's just opening up to all these different opinions and I find them all fascinating.

When listening to Lucy there was an overwhelming sense that the job has provided her with exciting new life perspectives, the freedom to explore many opportunities and to think about things differently. If this is how she feels now, I'm intrigued to know what stopped her from feeling this way before when she was a service user. Perhaps being a service-user (or the stigma attached to being a service-user) restricted her ability to form these ideas and have options. I find it interesting that Lucy feels it is ground breaking to have different opinions, perhaps choices, when I would feel it is a basic human condition and right. For Lucy, it appears to go beyond the association of financial opportunities providing her with choices, given that she had been employed immediately prior to accepting the PSW post.

The relationships with the RPS moved beyond a supportive relationship for six participants towards becoming a role model. I have interpreted that this experience heightened their awareness of their existence in the PSW identity. Furthermore, participants started to consider their relationship with the RPS and often incorporated an approach to help RPS move towards positive change. This is captured when Hannah explained the importance of being living-proof:

I always say to every single service-user I work with. I have total faith in you, I believe in you because if I can, anybody can.

Hannah's motto for me raises questions around being an example of recovery and how a person distinguishes between wanting to inspire hope and overburdening the person with expectations. When Hannah uses the word faith, it invokes in me her loyalty to the individual but also the reliance of them in recovering. It would be interesting to find out how the RPS experienced this.

I have interpreted that six participants gave evidence of awareness of a changing social self in relation to group belonging. When speaking about PS, Nadia simply put:

I think I-, we've been quite accepted by the practitioners in the team.

Previous work experiences had left Nadia *'feeling really worthless and de-skilled and like I'd never work again'*. Earlier in the interview, Nadia had explained she had left her last job in *'really difficult circumstances'* after managers had informed her that they were unable to support her and felt she was *'unsafe'* because of her MH difficulties. A lack of group belonging was further compounded by an absence of understanding from her previous employers whereby her MH difficulties were seen as *'something alien or other'*. For Nadia to now feel accepted is a clear departure from her previous experiences. This is supported by her sense-making of the interview process for the PSW post:

So to actually go and do an interview, where what I'd experienced, if that could be seen as a positive and that I could draw on that to go and relate with other people and support other people, was almost to me, probably not revolutionary but definitely radical.

This is an obvious contrast from her previous experiences and how other employers' have generally reacted to her MH difficulties. Nadia is perhaps compelled to select fervent wording or simply understands the concept of PS as 'radical'.

With the aid of metaphors, Simon similarly compared past experience to gauge current group belonging. In relation to MH difficulties, he explained how in the past he had managed his problems in isolation:

Er when I was in the darkness [unwell], you sort of run with the pack and I've never really run with the pack er I've always been a lone wolf.

Currently, rather than escaping the 'pack' (interpreted as other people), he is encircled with 'beautiful', possibly like-minded people:

Where I am today. Where I feel happier erm I'm not surrounded by those people anymore [past friends] I'm with beautiful people [recipients of PS].

In contrast, Pauline's general experiences within the role had been negative and this dominated her interview. In particular, Pauline struggled to understand her lack of group belonging when relating it to previous employment. Pauline's response below gives the sense of her having prior expectations before entering the PSW role about how she would enact it and how she would be received into the role, which perhaps left her feeling disheartened:

I feel very difficult in the team. I've never had a problem in a team before about when you have meetings, speaking up (..) stating how you feel, erm (..) I'm usually forthcoming with my opinions and things like that and I feel I haven't been able to...

It appears that the transition and working in the service she has been attached to, has been debilitating and alienating for Pauline, to the point that it has left her without a voice and a conclusion that '*I don't feel I've got myself back.*' There is a clear sense of loss for Pauline and a change for the worse. The team environment serves to undermine her personal recovery.

4.1.2 Recovery, growth and acceptance

When considering the transitional experience, all participants detailed experiences of recovery, growth and acceptance. Nadia outlined her relationship to recovery when depicting growth:

I'm at a really good place in my life right now ...I really like how I feel now, I feel very balanced and very settled and very tuned into what my warning signs are and I take remedial measures very early on.

Simon captured his understanding through metaphor and provided a tangible idea to his thoughts which I have interpreted as growth:

I'm still learning, I'm always learning, always ever learning, and once in recovery, always in recovery in my opinion, er yeah I feel like I have my wings back, I feel like I'm flying sometimes... but I never get complacent with that.

Simon further elaborated:

I've changed. Totally...I have much more respect for myself. I am much more aware of my own wellbeing, what keeps me well, keeps me happy er and what doesn't.

Although Nadia and Simon express the positive changes they have encountered, they both project in their language the temporary nature of their recovery and feelings of being in a good place (i.e. 'now' and 'never get complacent'). In both accounts there is indirect reference to relapse. I've interpreted that both view their current state as tenuous, with both preparing for the happiness to be transient and with recovery they are alert to the possibilities of relapse and the need to have measures in place. Although there is the feeling of recovery and being able to control the symptoms of future illness, it still threatens to reoccur for them. This again resonates with recovery and indeed the PSW role being a journey and open to fluctuations.

I understood five participants to have developed a more open sense of self, which generated discussions around being liberated and not hiding the self. The PSW identity was viewed as supporting this transition:

Hannah: ...Being able to be really open about who I was, where I'd come from, what I was doing, where I was in my life now, not having to hide behind anything and lie.

Nadia: ... Coming through a period of un-wellness, was a positive rather than something (..) that I would have-, that wider society would almost encourage you to self-stigmatise, so that you keep it as a hidden thing

When Hannah and Nadia spoke, there was a sense that the PSW identity was much more than being free to reveal their experience of having MH difficulties. For Hannah it has completely changed her thinking and her ability to disclose her life history and perhaps not be ashamed of it or who she is. Nadia was more explicit with what she once hid from; the social disapproval and personal discontent of being in a stigmatising position.

In contrast, four participants detailed barriers to recovery, growth and acceptance. Aspects of the PSW identity created a loss of agency and absence of control, with some participants focusing on a sense of frustration. Lucy

articulated her annoyance at part of the PSW identity and highlighted its potential to make her identity immovable:

...there's something about becoming a peer support worker (..) that bugs me, that you're always going to be in that sick role (..) so I don't know if people might see me as (...) always being "she was unwell once", or something. So that always sits uncomfortable with me...

Lucy again reiterates the juxtaposition of the PSW identity with it being emancipating and constraining. Lucy got the job because she was in the sick role, was liberated from the initial experience of the PSW role but this was possibly a temporary state for her and the realisation is that the PSW identity continues to restrict her freedom and she endures the labelling experience of being a 'patient'.

For Pauline whilst making sense of her experience, she questioned her decision to be in the PSW role both at the beginning and at the end of her response. Her answer is peppered with doubt and possibly regrets:

...do I really want to be in this sort of work, you know (...) and that's what I mean about keeping me stuck where you know, I'm feeling sort of er (....) (...) I suppose not feeling 100% myself really and question what I'm doing.

The continued hesitations in Pauline's account suggest that she is still making sense of her experience. However, it appears that not only had the PSW identity created an immovable state for Pauline, it has positioned her in a feeling of being stuck and has prevented her from continuing her recovery.

4.1.3 Difficulties managing multiple identities

For all participants, there were difficulties managing multiple identities during their transition. I have inferred that the previous ordinate themes enabled participants to make sense of these roles and the interchangeable relationship between them. However, it was extrapolated that at times, multiple identities created a level of discord with all participants when negotiating their differing

identities within their new position. This created conflict or an element of 'stuckness'.

When Peter made sense of his identity within PS, he offered a powerful reference to the Quaker philanthropist William Tuke⁷. Peter attempted to emulate some of Tuke's work through PS and aligned himself with the patient identity and the rescuer:

...Going into the asylum and the Tuke thing, going into the asylum and saying "I'm taking the chains off" (...) [makes a thud] OK that puts me in a rather arrogant patronising- , but "I'm standing with you because here's the marks in my [points to wrist] I'm not standing- , I'm not doing the professional thing with you"

In contrast, he later distanced himself from PS and subsequently identified with being a professional, seeing himself as being both part of and not part of, the system:

I want to be one of the boys, so to speak, one of the girls...I just want to be "ok Peter a great guy, oh yes he's peer support second, long, long, long way second.

Assimilating a professional identity with a patient identity is attainable and professionals working in MH services whilst actively using them has been well documented within the recovery literature (see research into recovery, 2011). However, it appeared that Peter had made sense of his experience by creating an either/or situation dependent on context, leaving an indefiniteness to his sense of self. It could be argued that he had taken a both/and position and created flexibility dependent on situations, thus shaping multiple social roles for himself. However, as outlined in the journal paper, he actively rejected part of the PSW identity. Subsequently, I have interpreted that rather than congruency between the professional and patient identity, they were less compatible for Peter, causing him some conflict.

Lucy explicitly highlighted the dissonance between the two identities:

⁷Tuke introduced new, more humane methods of caring for the mentally ill after being appalled by the conditions he witnessed in the 1700s (BBC, 2011).

It's very difficult to go to the team as a professional when people in that team know so much about me, that I wouldn't want anyone else to know (...) How can they see me as a professional (..) when all they've seen is this traumatised person (..) patient really (..) so (..) (..)

Lucy's account contrasts her previous reflections when the role was considered to be almost enlightening. Here the role is very much portrayed as exposing her vulnerabilities and preventing her from being taken seriously as a professional because with her PS identity comes her patient identity. For Lucy, there appears to be a paradox with her new found identity, it both liberates her and almost oppresses her.

Similarly, Scarlet struggled with the complexity of the service user and service provider identity and actively reflected upon these predicaments within the interview and where to place herself within the PS identity. This is poignantly conveyed when she recalled her first day in the post and her experience on an inpatient ward, which she had previously been detained on:

There's me, the care coordinator and the doctor and erm and talking about a client and it just not being me. And it just, just being about somebody else ... I was just like "Oh god this feels really strange, [laughs] feels really strange" and I was looking out thinking "I used to be out there looking in here and ooooh different" [giggles]

Scarlet's 'strange situation' turned 'bizarre' when she was asked to go into a review meeting with a patient who was interested in PS and was faced with meeting the consultant, who happened to also be her consultant:

I was like [shouts] oh my god, what a first day" [laughs] ... I just like-, this feels very very strange [giggles] and we sat in a room and this poor girl came in and I sat next to my consultant who I still-, who I used to see at that time...it was just one of those really bizarre experiences that [raises voice] I'm not sure I'd want to repeat again [laughs].

The use of pauses, false starts and self-corrections in the above passage suggests Scarlet is still actively making sense of her experience. Previously her responses had been fluid and uninterrupted, providing a coherent narrative. However, she was able to outline the paralysing consequences of the experience and the need to revert to a state of survival:

I wasn't able to contribute that much, or advocate for the person [laughs] but I was just surviving the ward.

In reaction to the situation, Scarlet experienced a panic attack after being reminded of her experience on the ward:

“oh my god it's a ward. the doors are shut now, I can't get out! (..) OH MY GOD. Are they going to let me out? [voice raises] Am I ever going to get out?” [laughs]

In the above passages, I have inferred that Scarlet used humour and focused more on the 'bizarre' aspects of the situation in attempts to control her emotions during this overwhelming experience. Underlying this experience, Scarlet reflected on her strong sense of patient identity, reinforced by the experience of being on an inpatient ward. Consequently I have interpreted that this created barriers within her transition and impacted on her ability to move forward into her professional identity.

4.2 PSW Role

This superordinate theme incorporated participants' sense-making regarding their job and was broadly encapsulated under the subordinate theme titles: 'role certainty', 'role vagueness and difficulties' and 'boundaries and disclosures'. Participants often referred to the present or were actively sense making when capturing this experience.

4.2.1 Role clarity

All participants detailed core ingredients or principles often affiliated with the PSW role (Clay, 2005) as a way of increasing the clarity of the role. It appears that this supported their transition and provided them with a clearer sense of purpose and definition of the role. Furthermore, some of the participants drew on their own experience of recovery or processed the role in relation to what they would have found helpful when they were unwell. This is captured when Nadia reflected:

... I kind of thought, would I have liked something like that when I was unwell? I-, and I think that I really would have done. Somebody (..) to speak to or just to listen to me or be with me.

In relation to principles, Clay (2005) asserts that peer relationships are based on shared experiences and values and are characterised by reciprocity and mutuality, whilst also encompassing 'equal standing'. This was particularly evident for Simon:

... Showing you the tools, perhaps showing you how to use them. So its sharing and they're [RPS] also teaching at the same as well.

Additionally, there was emphasis on the relationship being person-centred:

Hannah: ... So it's very very individual obviously, to what people want, what people feel they can do...

And promoting autonomy, meaning and acceptance:

Pauline: ... I think sort of obviously giving them support and (..) help them find solutions for themselves and giving them sort of information to help that process, (..)

Nadia: ... I don't think "oh that's a symptom of this and that's a symptom of that." No that's just how you feel when you just, the point or the purpose of your existence has drifted away from you but it can come back and sometimes that's all people need is to be alongside while they make that journey back (...)

Finally, when considering the peer relationship, participants reflected upon inspiring hope and recovery:

Simon: ...Inspiring hope and providing hope, that there is more to life then what-, maybe- that there's more to life if you want it.

4.2.2 Role vagueness and difficulties

Essentially the role clarity was largely informed by the recovery literature and often a conceptual understanding was apparent before the participants properly encountered the role. This was either achieved through previous experience, PS training or the PS job description. I have interpreted that once within the role, the translation of the theoretical principles into practical principles remained to a large extent straightforward, but some aspects incorporated role vagueness and difficulties. Consequently, the transition was met with problems and uncertainty. This was experienced by five participants and is epitomised in the following quotes by Hannah:

....It's difficult...I suppose if you're going to be a social worker, you know how to be a social worker, but to know how to be a peer support worker is a bit different because there isn't anything like it [laughs] so and we're the leading Trust in it, so - , it's quite, yeah we can't go anywhere else...we're supposedly the leaders at the moment so (..) where do you go? [laughs]

Hannah further compared the situation to a seesaw analogy:

I think we're constantly on this see-saw when we could be perfectly balanced but we could tip one way or the other, very very easily. One wrong decision could destroy peer support. One right decision could make it amazing, but who knows what those decisions are.

Hannah detailed the problems of not having previous behaviours, examples of successes that she can emulate in the new role. It is almost ironic that PSWs represent being a role-model but have no role-models themselves to support their enactment of the role. Hannah litters her responses with insecurity and instability which is epitomised in her seesaw analogy and perhaps the need to tread very carefully to maintain equilibrium between the advantages and disadvantages of a PS service.

Additionally six participants detailed occasions when the role had had a detrimental impact on their own well-being, they felt overburdened or felt the negative impact of the stigmatisation of the role. I have inferred that these experiences prevented the participants from feeling empowered and fulfilling the values outlined within the *role clarity* theme. The following quotes are offered because they typified the essence of the themes:

i) Impact on own well-being:

Pauline: it's got like where I've got to plateau and thought yeah I can cope with this and you know it's come again where, you know-. It goes in dips really and I've felt er, you know it's not been er good for my own wellbeing (..) but now I feel I can't walk away from it [laughs].

Far from enjoying the PSW role, Pauline is coping with it. She is investing cognitive and behavioural efforts into managing the demands of the job at the expense of her happiness. Despite this impact she refuses to quit, perhaps

because it would incorporate failure or she has developed loyalty to the role or maybe the alternative is no better.

ii) The feeling of being out-of-their depth within their role:

Nadia: ...Things I guess are sometimes quite tough because some people will really really unload about how down they're feeling and (...) and I think sometimes I do feel a bit lost, I think where do I run with this?

Nadia details the emotional burden felt when handling another person's distress. The use of the word 'lost' signifies Nadia's inability to find her way and this gives the sense that Nadia feels she lacks the skill to manage the situation.

iii) The implicit nature of stigma with the PSW role:

Peter: ...I'm not being nasty, but you know, you're in a different role. And [chuckles] you're the mad women in the attic, you know. You're the resident nutter [laughs]. There's a certain irony to it.

Peter vividly captures his understanding of the mockery of the PSW role and the externally labelled position of having to be 'mad' to undertake the job. Perhaps the irony is that stigma of MH problems normally prevents individuals from being employed but for this job he had to positively label himself to ensure he met the personal specification.

4.2.3 Boundaries and disclosures

When considering boundaries and disclosures, Lucy reflected on well-defined ones and explained:

I think it's quite clear, it's quite an emotional (..) I would never tell anyone that but I can share that, sort of- , your instinct tells you (...)

Simon employed professional boundaries to support his role:

I have to be very careful, boundaries are always very important...we have to take a professional stance ...I always make it clear, the service that I'm providing is a service-, it is me and part of me but it's not all of me.

Contrary to clear boundaries and disclosures, all participants reported a continuing sense of obscurity within the PSW role. This theme often interplayed with the fluctuating identities superordinate theme, particularly the subordinate theme; difficulties managing multiple identities. Internal dilemmas arose when PSWs were assuming differing roles. External conflict occurred when the service, staff or recipients placed a non-preferred identity on the PSWs. The participants consequently described complicated reactions in relation to trying to manage blurred boundaries. This is depicted when in contrast to Lucy relying on her instinct to provide clear boundaries and disclosures as stated above, she contemplated within the interview the problematic nature of boundaries and when these had been ineffective for her:

... there has been times (...) where I have shared a little bit more and I've come away and felt a bit uncomfortable about that...when you start sharing with somebody then, you think oh this is great, we've got so much in common...and then you come away and think, oh actually I didn't really want to tell anybody that, so it's difficult.

Equally, Nadia reflected on the complexity of maintaining boundaries:

Nadia: ...Peer means equal ...but I kind of have boundary within the boundary...

Interviewer: ...And you talked earlier about filtering things and I think that was in terms of what you would share and what you wouldn't about your own experiences.

Nadia: ...Absolutely

Interviewer: ...How do you do that?

Nadia: ...It's really hard Gemma, really really hard...

Furthermore, Simon outlined the blurred identities that can occur when working with RPS and when being mutually dependent created challenges for him:

... You've built a relationship on dependency and co-dependency. Because you're dependent on me to provide a service and I'm dependent on you for you to use that service and make me look good. When it's not about me, it's about the individual. So that it-, that is one of the challenges and dilemmas that I think may come along when working with people.

Lucy, Nadia and Simon detail the concerns around indistinct boundaries and the emotional impact it can have on them. There seems to be no easy answers with

how to resolve these difficulties and an element of vulnerability continues to exist.

Finally six participants explained the blurring or potential blurring of the role with other professional responsibilities or with being a menial worker:

Simon: ...I think they may want to be using me as a dogsbody, er I've been called cheap labour [coughs] I've been called a fad. Er and a phase to phase out [coughs].

Hannah: I think in a year, I'll be so dissolved in your team, I'll forget what peer support is all about and I think that could be quite easy to do.

Nadia: ...And you would hope it would not become a sort of (...) a cheaper version of a CPN...I think there is a potential for that to be subsumed erm we just become somebody else who can take medication out...

The above quotes challenge the philosophy of PS being a unique service. Simon, Hannah and Nadia outline the dispensable nature of the PSW role and their fears that it might not be taken seriously enough as a distinct service. Furthermore, Simon refers to derogatory comments that have been made about him which go beyond the blurring of the role and overlap with the subordinate theme 'role stigma' and possibly create barriers for the subordinate theme of 'reconnecting, recovery and taking control' within his PS identity.

4.3 Organisational Culture

This superordinate theme incorporated participants' sense-making regarding their experiences of becoming a PSW within the NHS MH system. Interpretation generated elements which have impacted on the participants and were broadly encapsulated under the ordinate theme titles 'changing the system' and 'supporting attitudes and barriers'.

4.3.1 Changing the system

When understanding their position as a PSW within the NHS MH system, all participants reflected upon changing the MH system, with a desire to alter the

basic assumptions underpinning the NHS; from a medical approach to a person-centred approach. Scarlet explicitly rejected the medical approach and understood PS as an opportunity to change the ways of working:

...Peer support was able to do, was to come at, sort of recovery, erm and come at supporting somebody that's already in their journey (...) from a completely different angle from the medical world.

Lucy highlighted the current lack of a recovery-based and person-centred approach within the NHS. Within her quote she portrayed a sense of powerlessness that can exist when in a service:

I think a lot of the NHS services; it feels like they are doing it for you or to you...

Three participants developed this subordinate theme further and highlighted the relevance of 'experts by experience'. Scarlet captured this when she made distinctions between the expert by experience and expert by knowledge when discussing a medical colleague:

...Your reality is your textbook, well my reality is my life and my experience and to me that was always a lot more valuable and a lot more real... Obviously she's got the expert from the medical side and I'm sort of expert from the service side.

Scarlet details the importance of first-hand experience but in doing so she makes a distinct separation of medical knowledge and experience with them encompassing different realities. This gives the sense that they are unconnected but is also perhaps a way of justifying her role and the need for PS.

Four participants explicitly challenged the existing practice within the NHS. Lucy's account highlighted the failures of the current system which dictates predetermined pathways in such a dehumanising way, that she felt she needed to support the individual to feel more human:

They've got a set treatment path and they know exactly what you should be doing and they see you in terms of this diagnosis and that's how they're going to treat you...what I wanted to do when I took the job was just to get to know somebody ... maybe help them to see themselves maybe as more human.

Additionally Scarlet, through tears, emotionally portrayed a narrative of 'battling' with life, and 'fighting' an oppressive system [see Scarlet's previous quote outlined in the journal paper to support this interpretation]:

When somebody's in a ward and they've got nothing and they're literally...forced out of their home, they've been taken into somewhere that they don't know, is not familiar, they've never been in before...then they're discharged. How does that person deal with their life, you know [gets physically upset, begins to cry]. I think it's something that's so close to me, that it's a real fight, it's a real battle.

I have interpreted that participants could relate to these debilitating services with direct experience and reconnected closely to the loss of control and agency often felt. This is emphasised when Scarlet described how the experience was close to her.

In response to this powerlessness, five participants viewed themselves as agents of change. I have inferred that this position enabled them to justifiably be in the system and create change rather than being part of the incapacitating system:

Simon: ...I realised from looking at it from another side that in both worlds...I can see what it's like, when I was like that, what would have helped, could have helped me and what wouldn't. Erm and then also with the staff and how I can educate those people er as well as, by just changing the language and their approach towards people.

Hannah: ...they always say it's a person-centred approach, it's all about the service-user, but I think that is forgotten, a lot of the time and I want to help drive that forward...

Scarlet: ...my hopes are, is that I'll be able to influence the service in a positive way to be able to make it better for people and make it better for myself.

4.3.2 Supporting attitudes and barriers

When considering the supporting attitudes and barriers, the following quote by Lucy exemplified five participants' experiences of feeling valued and supported by other professionals outside of the PS service:

Lucy: ...They're just accepting me (..) and I think I've kind of accepted myself a bit.

Lucy experienced the secondary effect of others accepting her, in the sense that she accepted herself more. Consequently, I have interpreted that Lucy not only made sense of her transition in relation to supporting RPS with their recovery and acceptance but also that she too was supported with her own recovery and acceptance.

Equally, five participants described the invaluable support they experienced within the PS service, which was particularly useful when they were experiencing periods of being unwell. Nadia summarised this in the following quote:

...I had a bit of a blip in the summer when we were doing the training and erm, you know I got support from my manager, I just took some time off. She said "you'd go home if you had a bad leg"

In contrast, Pauline highlighted the lack of support owing to the unavailability of the project coordinator:

I went off on the Friday, I was terribly distressed, unfortunately the project coordinator only works (..) erm half the week.

In addition to the quotes offered within the journal article around lack of acceptance and support from other professionals, the following exemplar quote is offered:

Peter: ...“You're peer support? Ok, well look-, just...erm-”, the voice goes quiet- “go, and sit in the corner and erm, I'll- I'll show you want you do and <how> the photocopier works and WE"LL help YOU”.

Peter depicts a patronising reception he received from the team and the tokenistic realities of the role. Peter's work colleagues conceivably view PS as an administrative role [highlighting the location of the photocopier]. The parodied comment '*we'll help you*' suggests that Peter perceived the offer of help as maintaining a distinction between staff and service user, rather than acknowledging the value of his role within the team. I am left wondering how staff can support Peter in his role if they do not understand the purpose of PS.

Furthermore, Lucy outlined an ethical dilemma she encountered when she was sent a referral from a service she was still receiving care from. Additionally, she and the person referred were being seen by the same counsellor who objected to Lucy accepting the referral. During the interview Lucy recollected a therapy session with her counsellor:

One thing I said to my counsellor is that, I don't want to discuss, that's a professional issue, that's me as a professional, in counselling sessions, it's me as a patient and I need your help as a patient and (..) I felt like she wasn't listening to that and she wouldn't drop it.

Lucy outlined her emotional plea to her counsellor in keeping the two roles separate. However, her counsellor failed to respond to this request. Within Lucy's session she needed support as a patient and to be heard as a patient but got neither. Her experience highlights the almost double punishment she received from being a PSW or perhaps a catch-22. Firstly, her counsellor stopped her from being a professional when she vetoed her accepting a referral. Secondly, she prevented her from being a patient when she wanted to discuss professional issues within a counselling session. Lucy is left with not being able to embrace her professional identity nor her patient identity.

Finally, all participants described stigma getting in the way of empowerment. Hannah expressively encapsulated this when she spoke widely about the stigma within the NHS:

Hannah: ...I did a survey to find where stigma was found the most and the top three areas were accident and emergency, [local] in-house drug services and dispensing pharmacists...that isn't people on the street shouting "oh junkie, smackhead" you know, this is our service. This is all connected to the NHS, it's got to change.

This theme overlaps with previous subordinate themes whereby stigma either associated with the role itself or more generally with mental illness, has directly impacted on participant's ability to fully enact the role.

In summary, the purpose of this research was to explore the experiences of the PSW's transition. Participants described their journey in relation to making sense of fundamental aspects which either supported their transition or impeded it. These experiences were principally captured under the three superordinate themes: (i) *Fluctuating identities* (ii) *PSW role* and (iii) *Organisational culture*. Although previous research has described the PSW role, it has failed to capture the complex and variable process of the transition, which involves a number of inter-relating factors that impact on the transition.

5.0 Discussion

The aim of the discussion is to place the findings from this research into the wider context of the relevant literature and draw upon the parallels, differences and where this research offers novel insights. Within this section I have endeavoured to separate out discussion points to cover each of the superordinate themes. However, as I have previously stated, superordinate themes were interpreted as independent with each other with interrelating subordinate themes. Additionally, the themes loosely reflected a time dimension of preconceptions before entering the role (within the fluctuating identities), actively making sense of the role in the here-and-now (within the PSW role) and future aspirations of the role (within the organisational culture). However, the themes were not always situated neatly within these periods and transcended time. Predictably, discussion points are multi-faceted, with some themes being applicable to other sections. The final section critically appraises the research and provides strengths and limitations of the research, whilst outlining the implications for practice and offering recommendations for future research. The section concludes with my critical reflections.

5.1 Fluctuating Identities

Participants entering the PSW role spoke of a 'changing social self' which allowed them to move away from their own lived experience of MH difficulties (and for some their patient identity) and enact the PSW role. Similar to previous research (Davidson et al., 2006), role modelling supplemented this. The majority of participants described feeling connected to other people and communities. Similar to previous research (Moll et al., 2009) tensions between overlapping identities was evident for all the participants, particularly the 'patient', 'peer' and 'professional' positions. Essentially this was experienced through establishing a less formal, hierarchical identity as a peer but needing to maintain clear boundaries and professional practice within the staff identity. Further dissonance between the identities occurred when participants were reminded of their 'patient' identity, whether this was by means of landmarks (e.g. hospital wards) or through people (e.g. past care coordinators). Subsequently, the PSWs were left balancing these differing positions. Repper and Carter (2010) reported that

PSWs are “keen to move away from the professional role” (p.13) and it has been argued that it is important to avoid the professionalisation of PS (Basset et al., 2010). This was not necessarily the case for the current participants, rather a fluctuation between identifying more and identifying less with the professional identity, dependent on context. Participants appeared to favour a multiple social identities position.

The present study identified how all participants recognised elements of recovery, growth and acceptance whilst enacting their role. This supports previous literature which argues that PS can aid personal recovery for the PSWs in addition to the RPS (Bracke et al., 2008; Mowbray et al., 1998; Woodhouse & Vincent, 2006). It also supports the broader literature on recovery which has found that i) individuals who find acceptance and understanding of their mental illness, ii) redefine their identity and iii) discover ways to decrease stigma and help others, can facilitate the recovery process (Jenen & Wadkins, 2007). For the majority of participants in this study, being able to be open about their MH difficulties, feeling less shame and a sense of relief from not hiding was a core concept and resonates with previous research (Ochocka, Nelson, Janzen & Trainors, 2006) reporting that individuals participating in PS were less inclined to report stigma as a barrier for employment. However, this research highlights the intricacies of stigma and whilst making sense of their transition, most participants detailed the stigma attached with the PS identity which impacted on their ability to enact the role. Additionally, the process for most of the participants was that ‘recovery, growth and acceptance’, did not adhere to a linear path, but incorporated various drawbacks and challenges along the way. This reflects previous research on the wider change and recovery literature, where individuals progress through several phases towards integration, often returning to a previous phase in a process of continuing adaptation (Charmaz, 1995).

5.2 PSW Role

The role clarity was fundamental in everyday functioning, enabling participants to actively make sense of their new role and provided transparent theoretical

direction on how to support RPS in the here-and-now. In its basic form, participants were able to apply the role in a simple sense-making way and concluded that just 'being with' the RPS was a powerful enactment of the role. This reverberates with earlier studies which have suggested that service user provided services emphasise the 'being with clients' whereas non-service user providers emphasise the importance of 'doing tasks' (Paulson, Truscott & Stuart, 1999). Additionally, participants experienced role vagueness and difficulties. Previous research has highlighted the challenging nature of the ambiguous PS role (Mowbray et al., 1998; Salzer, 2002). This research has emphasised how it can be detrimental on a PSWs own well-being and can create conditions where the PSWs feel out of their depth. The experience of stress whilst in the PS role has been previously researched (Chinman et al., 2006; Mowbray et al., 1998) and the importance of support to help PSWs maintain their recovery and wellness during employment (McLean et al., 2009). In contrast, this research highlighted that for some of the participants the role can have detrimental implications on self-recovery, despite support being available and sought.

Vicarious traumatisation (VT)⁸ is documented within the literature and can result in burnout, secondary traumatic stress and compassion fatigue (Kearney, et al., 2009; Meichenbaum, 2007; Pearlman & Saakvitne, 1995). Research indicates that VT can increase anxiety, depression and poorer physical health (Stamm, Varra, Pearlman & Giller, 2002). VT can also result in poorer professional judgements (Pearlman & Saakvitne, 1995). Conversely, positive growth and a deeper connection with others can develop (Pearlman & Saakvitne, 1995). Some participants in this study reported feeling overwhelmed with the emotional impact when supporting RPS with distressing events. Although it would be premature to suggest they may be experiencing VT, research has indicated that sense-making is essential when helping an individual manage distressing events (Park & Folkman, 1997). For some participants, they struggled to make sense firstly of the role and secondly with how to support others when lacking the knowledge, experience and skills to deal with particular situations. This then interfered with a role that was emancipating and created a role that was constraining, generating

⁸Pearlman and Saakvitne (1995, p. 31) define it as the "negative effects of caring about and caring for others". It is the "cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material".

a sense of conflict with how to interpret the transition of supporting others when feeling unable to do this. This was further complicated by the implicit stigma of the role that labelled participants with MH difficulties and at times acted like a shackle, preventing some participants in this study from feeling that they are being taken seriously as a professional and believing other professionals struggled to look beyond their 'patient role'. Some participants resolved this barrier with perseverance and allowing time for all stakeholders to become accustomed to the new role, including themselves. Another strategy was to align the role more closely with their preferred identity, which was also changeable dependent on context. Finally, seeing the PSW role as an opportunity to challenge the organisational culture and to establish a more recovery-orientated service was a method to address the stigma and is discussed further in the final superordinate theme.

There is a continuing debate within the PS literature concerning blurred boundaries particularly around friendship or professional roles. Mowbray et al. (1998) found difficulties associated with PSWs providing a friendship role, whilst Mead et al. (2001) argue that egalitarian relationships with flexible boundaries support the PS ethos and minimise power differentials often associated with professionals. However, a review of the literature on PS in MH services highlighted the necessity of clear guidelines (Repper & Carter, 2010). Repper and Carter (2010) highlighted that certain practices were explicit in being prohibited (i.e. sexual relations) and needed no further exploration. Yet, issues around details of disclosures and levels of sharing were much more indeterminate. The review further acknowledged that ambiguities are likely to exist and therefore training needs to address the relevant procedures that regulate decision-making. The current research highlights that despite the participants undergoing such training, they continued to encounter blurred boundaries within their practice. This may suggest that training would be more beneficial if it supported individualism of boundaries (i.e. it varies from PSW to PSW) and encouraged PSWs to understand that they need to discover their own limitations of sharing experiences which may be a process rather than an immediate awareness and may change over time.

5.3 Organisational Change

Although influencing the NHS culture through the PSW position has been alluded to in previous research (McLean et al., 2009; Repper & Carter, 2010), the emphasis placed on the superordinate theme in this research is novel to the PS literature. All current participants made sense of their transition with the fundamental desire of being part of a future paradigm shift within the NHS practice to provide more recovery-oriented services. It is proposed that this aided the transition by enabling participants to find further meaning and purpose in the role at an organisational level. It also provided future aspirations of the role and produced a feeling of longevity with the PS service.

The study findings support the claim that fitting in or being accepted in the workplace can be a key transition point (Moll et al., 2009). The transition towards adaption and integration was an important predictor in participants reporting positive change and the potential for growth within their role. The support from others was paramount in fostering this. Previous research has suggested that placing PSWs into services that are not recovery-orientated can potentially generate compromised wellbeing for the PSWs (McLean et al., 2009). The current research supports these assertions and was expressed vividly for one participant in particular. Williams (2011) argues that PSWs function best when operating in settings which are already dedicated to a recovery-orientated approach. She stresses that PSWs should not be “expected to act as the sole agents of change” (p.8). Similarly, Bradstreet and Pratt (2010) emphasise that PSWs should not be perceived as change agents but regarded as having the ability to develop service effectiveness and positively influence service culture.

However, for the majority of current participants to view themselves as agents of change provided meaning to their role. Yet what remained problematic was how to implement this. It has been contended that service user provided services need to remain true to themselves and not imitate attributes of traditional MH services (Soloman, 2004). Previous research reports that PSW can reduce

pressure from overstretched staff (Mowbray et al., 1998). Both studies are possibly offering competing advice on the role of PSWs, further blurring boundaries and creating role confusion, which can impede the successful integration into an organisation (Gates et al., 2007). Corresponding to these concerns, the participants in this research made sense of the PS service in differing ways and felt it (i) supplemented services, (ii) were complementary or (iii) offered a unique service. Variable responses from PSWs as to the purpose of PS services has been previously reported (Moll et al., 2009). Regardless of how participants viewed the PS service, the nature of the role was seen as changeable over time and was dependent on how well they were received within the service they were attached to. Additionally, a supportive workplace culture requires more than being open to the idea of PS, the service may need to redefine its mission and goals to genuinely commit to PS. As previously discussed in the introduction, there is also the fundamental issue of Mead's (2003) theoretical explanation of PS not translating into practice and the current recruitment process being reliant on the medicalised and diagnostic criteria, thus maintaining the expert/patient relationships.

Finally, earlier studies have outlined the challenges associated with establishing effective relationships with staff teams, particularly whilst challenging non-recovery focused practice (Gates & Akabas, 2007; McLean et al., 2009). Practicalities of the job including limited hours can prevent PSWs from being able to properly integrate within the teams (Moll et al., 2009). This research further found that the lack of support owing to the reduced availability of the project coordinator was another practical limitation. Again feeling devalued and discriminated against through stigmatisation, underlined this superordinate theme. The recovery literature has identified general barriers to recovery relating to stigma from others and the MH system (Watkins, 2007) which limits the individual's ability to move towards positive change. The current participants discussed the stigma attached to the role and more widely within the NHS and how it constrains the peer identity. Stigma can impact on relationships with others and can result in the stigmatised individual withdrawing, losing social support networks and developing low self-esteem (Link, Cullen, Struening,

Shrout & Dohrenwend, 1989). Although there was no evidence of this for the majority of the current participants, it is worth considering.

5.4 The Wider Literature

The present findings reflect similarities with research found in the wider literature on role transitions and the interaction of identities. It is not intended that the small numbers of this research is generalisable but the following section aims to comment on whether the current findings support, contradict, or add to the available literature.

The experiences of participants in this study compared to earlier research that suggests individuals have a number of well-expressed inseparable identities linked to their individual, social and human characteristics (Parekh, 2008). The current findings appear to fit relatively well with the ideas proposed by Sluss and Ashforth (2007) who hypothesise that self-definition within an organisational context is partially determined by an individual's network of interdependent roles in addition to the personal identity and collective identity. Through the relational perspective of role theory in organisations, Sluss, Van Dick and Thompson (2011) argue that individuals endeavour to reconcile their natural pursuit for stability and security against the environmental pressures to change and flexibly respond to new forms of organising (Sluss et al., 2011). This is perhaps applicable to the participants in this research and possibly for the staff teams too considering participants are attempting to change the NHS culture.

Wheaton (1990) reports that MH issues as a consequence of life transitions can be minimised, if not eradicated, by the presence of prior stressful role problems. This argument may be supported by the present research whereby many of the participants described not accepting previous aspects of themselves and being debilitated by their previous 'sick role'. The PS role was seen as an opportunity of growth for most. For all of the current participants, the transition into the PSW role happened within their control and the majority of the participants were positive about entering the role, although some participants detailed their concerns about the stigma attached to the job title. Allen and Vlierts (1984) assertion that transitions are mediated by three conditions could have relevance

for the current participants in relation to (i) amount of discontinuity between the previous and latest role expectations, (ii) level of control over the transition, and (iii) degree to which the role transition is affected by normative governors. When considering the enactment of the role on psychological wellbeing, participants in this study reported a combination of feelings during the process of transition including happiness, excitement, fear, anxiety, dissatisfaction, frustration, sadness and being stuck. The process of transition detailed by Fisher and Savage (1999/2003) incorporates an element of these emotions and offers an explanation as to how people respond to change. However, participants detailed a process whereby emotions fluctuated rather than progressed through a succession of fixed emotional stages, as depicted by the model. The model accounts for differing rates of progression, regression to earlier stages and an understanding that participants may have advanced through a stage and not recognised or reported doing so. However, it fails to capture the complex and dynamic nature of change (Iles & Sutherland, 2001) and ignores the influences of the social world. Instead the model assumes a rational, controlled and orderly process, without offering empirical support for these postulations. This indicates that the Fisher and Savage (1999/2003) model is too simplistic to account for the individual experience and sense-making presented in this research. Petch (2009) contends that even transitions that are viewed positively and provide opportunity for growth can cause uncertainty and doubt. Findings in this research support this hypothesis in addition to the idea of role strain proposed by Allen and Vliert (1984). Ashforth's (2001) assertion that transitions considered to be challenges rather than threats are more successful also seems to resonate with the current participants, particularly within the 'organisational culture' superordinate theme and positively 'challenging the system'. Pearlin and Schooler (1978) contended that coping resources and responses, such as commitment, willingness and social networks aid transitions. When participants in this study struggled with the role enactment they identified the lack of commitment and lack of support as a precipitating factor in addition to the stigmatising nature of the role, which could be argued is associated with the lack of social network and group belonging.

5.5 Clinical Implications

This research has several implications for practice. NHS professionals and services first and foremost can use the findings to develop their understanding and awareness of the experiences of participants' transitions into the NHS PSW role. In particular, consideration could be given to the sense of complexity that frequently seems to dominate such transitions and the interchangeable relationships that support or impede the enactment of the role. This research demonstrates that it is important for staff to consider the extent to which their own roles empower or prevent PSWs from enacting their role. This supports previous research that has emphasised the need for services to be recovery-oriented in order for PS to experience optimum conditions (Repper & Carter, 2010). Although staff may be open to the philosophy of PS, it is policy, organisational and resource commitments that will drive forward the promise of promoting a culture of genuine commitment to service user provided services. These commitments need to ensure that PS programs are integrated in mainstream services, not an add-on, which could potentially be subsumed by other services.

One of the most alarming findings in this research is the way that some participants found entering the job and without sufficient preparation experienced distress, particularly when going onto inpatient wards or working closely with professionals who had once been responsible for their care. This resulted in the participants feeling powerless and a loss of control. The need for self-awareness, self-care and the ethical responsibilities for employers are paramount when considering the minimisation of distress and burnout for PSWs. Educating PSWs to better develop their self-awareness may initially expand their coping responses, in addition to PS (Kearney, et al., 2009). Engaging in emotional, cognitive and behavioural self-care behaviours have been previously recommended (see Meichenbaum, 2007, for practical strategies) and the need for a work-life balance (Hesse, 2002). These methods could be effective in supporting PSWs.

Additionally, there were instances when other professionals misunderstood the PSW role and some participants reported staff feeling threatened by their presence. This became particularly problematic when PSWs were still receiving input from services. The above experiences highlight the need for properly thought out provisions for receiving PSWs and the need to suitably prepare services. For example, information about the PS service in the form of a leaflet may be beneficial for services, particularly if it clearly outlined what PS is and is not. Additionally, one participant recommended that if she had been given the opportunity to outline what she would like and not like her first day to consist of when she was initially attached to her team, this would have prevented her from experiencing such distress. Finally, the use of PS could be applied to PSWs once services become more established within the UK. The participants delineated the uncertainty of the enactment of the role and the unavailability of examples. Establishing a PS network of established PSWs could support the transitional experience for individuals new to the post.

Finally, the findings from this research suggest that in order for PSWs to make sense of their transitional experience, flexible support is paramount and further clarity on the role of PS warranted. Underlying these requirements is the importance of the transition being a process, the need to allow sufficient time for this and the understanding that problems arise in different contexts. Additionally, for the current participants, this process was not linear and fluctuations when enacting the role were experienced, particularly in relation to others. Drawing on the wider literature, managers may support work role transitions through a process whereby individuals utilise narrative repertoires to explore narrative identity work in role-related interactions. Following feedback, stories and repertoires may be revised until a completed transition is facilitated and long-term and consistent repertoire changes are articulated with the new role identity (Ibarra & Barbulescu, 2010). This approach could offer insights into how an individual forms and maintains an identity whilst recognising the importance of social structures within the process. However, the approach would not explain why change is happening.

5.6 Strengths and limitations

The study findings illustrate the significance of employing a qualitative approach when exploring novel phenomenon. An important strength of this study is the fact that it is the first piece of qualitative research to explore the transitional experience of NHS employed MH PSWs. Furthermore IPA enabled me to move beyond description and offer interpretation of these experiences. I was also able to consider convergence and divergence within the data set and move between the individual accounts and the shared accounts. The limited research in this area has mainly focused on the benefits and challenges of the role rather than the processes and how it is interrelated with the relationships between individual, interpersonal and collective identities. The current research uncovered features of the experience which were important for the participants when enacting the PSW role. However, my critical realist stance and the subjectivity of IPA purports that the findings are tentative, although the process of attaining them has been meticulous and methodical to ensure the reader can track my decision-making process and check the quality assurance of the data. The research was grounded in examples to illustrate both the analytical procedures used within the research and the understanding developed in light of them. I further acknowledge that although I appraised the findings in a particular way, another researcher may conceptualise possible alternative meanings and understandings (Elliott et al., 1999). The use of in-depth qualitative research was used in this study to contribute to the theory base and was consequently used flexibly to each participant, yet quantitative studies may possibly provide more information about PS in general. Certainly the critical realist perspective could advocate a multifaceted approach to studying this experience so that multifaceted perspectives of the experience are represented.

In evaluating qualitative research, Elliot, Fischer and Rennie (1999) suggest the importance of situating the sample. This relates to the research offering a detailed description of the sample and their personal circumstances with the purpose of enabling the reader to make judgments about the types of individuals included in the research and the circumstances to which the findings apply (Elliott et al., 1999). Due to confidentiality issues I chose not to describe each

participant in depth. However, I did provide basic demographic details. Finally, the semi-structured interview presented a convenient way of aiding the participants in developing a temporal sequence around their experience of transition, and worked as an anchor point for the interview although it was used flexibly. On reflection there was a mass accumulation of data collected from the interviews and it may have been more beneficial to have gained a deeper understanding of the experience through the use of fewer questions, although there are no assurances that a deeper understanding would have occurred.

5.7 Future Research

The current research provided an insight into a number of areas which would seem to warrant further investigation:

1. Given the relevance of transitions being a process and the need to provide sufficient time for these processes, it might be beneficial to conduct a larger scale longitudinal design to map trajectories of role enactments and how individuals circumnavigate their transitions. This research has only captured a snapshot of the PSWs transitional experience. Role transitions are a process therefore there is no definitive way of establishing when an individual exits one role and enters another. However, longitudinal research could commence at an earlier point of the PSWs transitions (for example when individuals are applying for the posts) to when they leave the PS role. Furthermore, conducting longitudinal research which permits the experience of transition to be discussed as it occurs reduces the problems associated with retrospective accounts.
2. Further research with the RPS and the staff groups would be useful given the importance of role relations identified in this research. Being key stakeholders it would be beneficial to gain their experiences and sense-making of the PS service.
3. Following on from this research, areas that warrant further investigation would include a more detailed examination of the interplay of distress, recovery and stigma when enacting the PSW role.

4. Other qualitative approaches such as discourse analysis might offer new insights into the PS transition. Some participants expressed the importance of recovery language during the interviews and all participants peppered the interviews with the use of 'lived experience', 'recovery', 'being with'. Although they used the terminology frequently, when pressed for further elaboration there were difficulties.

5.8 Critical reflective component

This final section offers critical reflections of my research project and considers the scientific, ethical and theoretical issues which have been raised throughout my research. I have detailed challenges and key decision making processes I incorporated to address these.

Theoretical issues

Throughout the research process I found myself thrashing out my methodological choice. I felt confused about the different qualitative methodologies and made constant attempts to untangle the overlapping methodological approaches and understand why IPA was chosen and offered more than a thematic analysis drawing on a latent and inductive approach. These deliberations and subsequent sense-making are epitomised in the following reflective diary entry:

Some of my cohort met today for our qualitative methods meeting. We introduced our methodologies and offered rationales for deciding upon that approach. Although I made reasonable justifications for using IPA, I was left wondering whether I'd jumped onto the IPA bandwagon and had simply been enticed by a 'brand' that was nothing more than an amalgamation of other forms of qualitative analysis? Yes it offers interpretation rather than mere description but this is possible with other qualitative methodologies i.e. recent strands of thematic analysis and grounded theory. What does IPA add to my study? It is attached to a phenomenological epistemology which gives experience primacy. It enables me to explore, in great detail, the nature of experience and what it is like to be a PSW (although I can never completely access the meaning and IPA acknowledges this).

OK so I can get a greater sense of the participant's world and understanding of the

phenomenon in question but why did I not choose an entirely phenomenological analysis? Phenomenological researchers are concerned with experiential meaning but there is a continuing debate about the theory to practice shift. IPA offers a method of bridging this gap and turning philosophical theory into an analytical concept which can offer implications for clinical practice with a psychological focus. Finally, phenomenological analysis has been criticised for neglecting the interrelated nature of the researcher and data, whilst the double hermeneutics in IPA enables me to consider my previous experiences and knowledge.

Another theoretical issue ensued when considering the usefulness and appropriateness of utilising IPA with my data set and being faced with a number of conundrums. On the one hand it provided me with interesting insights into the subjective processes involved in the complex area I researched. It afforded a richness of participants' accounts enabling me to utilise a position of qualitative enquiry embracing open curiosity to the developing nature of research. However, in my search for connections, similarities and divergences across cases, did I miss opportunities to utilise a richer layer of data that could be offered from a single interview (Collins & Nicolson, 2002). Indeed three of my interviews were over two hours long and offered a wealth of data, one participant out of the seven had never received MH services and a further participant had regretted their decision to become a PSW. All these single variances provided enough data to constitute a doctoral level piece of work. Although single cases are advocated in the IPA literature (Smith et al., 2009) I felt that this would be frowned upon and the course requirements would require more than one interview although this possibly says more about my assertions and positivist positioning regarding the more participants the better. Furthermore, it highlighted my doubts and naivety in entering a new methodological approach and I felt that at least if I had a 'bad interview' with not much data, I could hopefully rely on others compensating for this. Despite these concerns, I was left with the prospect of having enough additional data to write a further three or four papers and the opportunity to complete single-case studies. I feel this now provides me with the possibility to utilise a richer layer of data from single participants.

However the volume of data accumulated during this research brought about another challenge of being overwhelmed by my analysis, how to start it and when to stop. This was further complicated by the interpretative element and the

deliberation over what is good enough interpretation. This is encapsulated in the following reflective diary excerpt:

...It's illuminating to be this absorbed in the data but the magnitude is overwhelming, when do I stop analysing, how do I stop? What should I include in the final write up? Also what is good enough interpretation? I'm finding it difficult to discontinue my evolving analysis. I do feel some sense of relief after consulting the Smith et al. (2009) book and finding that it is reasonable to continue analysis during write up. When it comes to the interpretation I am mindful of staying close to the data but am keen to move the data to another level and offer my interpretations, whilst obviously being able to justify them. But IPA is inevitably subjective and no researcher will see the data in the same way. This works well for exercising my interpretative skills but potentially raises validity and reliability issues. Being transparent in my analysis I guess is the answer. I like Willig's (2001) summary that being a new approach IPA allows a researcher to have more freedom and creativity. Although I think this may now be a little out-dated, particularly the unintended cookbook, actually being a cookbook because so many researchers are new to the approach. I feel the book has kept me on track and provided options when I've struggled but I continue to think about it with the roadmap analogy (Gee, 2011).

In addition to utilising my reflective diary and consulting the guidelines offered by Smith et al. (2009), supervision was particularly important at this stage to help refocus my efforts on the aims of the research. However, it was difficult to put some of my analysis to one side. Again the prospect of reporting the findings in subsequent articles elevated some of these concerns.

Finally, when it came to writing an article for the journal of MH the realisation of communicating my findings in a pithy manner dawned on me. IPA seems incompatible with the demands of conveying your findings in less than 4000 words. It's an intricate process and to outline this whilst also reporting on all the superordinate themes necessitates only a glimpse of my analysis. I was faced with the possibility of not reporting all my superordinate themes. However with the interrelating patterns of the subordinate themes, it seemed that even if I could decide which superordinate themes were more relevant to my target audience, I would still be faced with dislocated results. Fortunately the editorial team were sympathetic to the challenges of condensing qualitative research and were prepared to consider an article of approximately 6000 words. Nevertheless, this is a temporary solution and does not entirely rectify the problems of

pragmatically communicating IPA in a succinct way. Another solution to ensuring the findings are accessible is to present them to various groups within the NHS whilst supplementing my research with an understanding of IPA methodology.

Ethical issues

A key ethical dilemma for me during this research was to be a researcher and not a clinician, particularly when individuals were disclosing information of a very personal nature and at times became evidently distressed. I was mindful of being sensitive to these experiences and the protection of participant harm whilst also being aware that a study aim was to disseminate the findings for the practical use of other PSWs and professionals in the MH field. This was reflected in one particular diary entry:

I was struck by how traumatic Pauline's experiences have been and its obvious impact on her recovery process...I found it difficult to step out of the role of a clinician and into the role of a researcher as I felt I needed to be responsive to Pauline and her distressing experience. Pauline questioned the relevance of what I was asking, I had not experienced this before, maybe it was a protective barrier for her? I backed off...Although she seemed to be encouraged by my reiteration of the purpose of the study, being directed by what she wanted to say and the option of terminating the interview. Pauline continued with the interview, I was very sensitive to her body language throughout. Perhaps I was fearful of her becoming 'uncontained' and 'unsafe' because her emotions felt so raw. I found it difficult not to start formulating some of her problems and needed to actively disengage with my clinical experience whilst in the interview. Although I couldn't help feeling like I was taking advantage of somebody's vulnerable situation and it felt unethical. A publication in an open forum is very revealing. I feel additional pressure to protect Pauline's anonymity. What I was able to do was to follow my procedures denoted in my ethical approval, outlining the actions I would take to minimise distress. I spent time on the debrief at the end of the interview and reiterated the option of a follow-up session with the clinical psychologist or withdrawing. I was left wondering whether the interview was a positive experience for Pauline and whether she felt validated for being able to tell her story or whether the interview made the situation all the more real. I took some comfort in Pauline's words when she explained that it was important to tell her story and hoped it would help others in the future.

Hutchinson and Wilson (1994) outline the potential benefits of participating in research and propose it can validate the participant's experience, provide empowerment and offer an element of healing. This was reiterated in my interview with Peter when he explained that he had found the interview

experience enjoyable and felt it had been quite therapeutic. Perhaps there are more similarities between a therapy session and an interview than I first envisaged. Secondly, my study had approval from the NHS ethics committee, participants were fully informed of the risks, were able to withdraw and I had contingencies in place that supported me as a researcher to manage distress rather than feeling the need to adopt my clinician role.

Another predicament I was faced with, which also permeates my clinical practice, was the inherent power imbalance between the researcher and the researched. I was able to minimise this during the interview through procedures such as being guided during the interview by what the participant said rather than rigidly following my interview schedule and providing options for her, such as stopping the interview or withdrawing from the research. However, I was aware that post interview the participants accounts were controlled by my analysis and my interpretation. To address this, I was honest about what my research was about and my chosen methodology. I explained why I didn't ask for participant feedback (member checking difficulties) but offered every participant the opportunity for a summary document of the findings, the journal paper or the full report. All participants requested a summary of the findings, which will be disseminated following feedback from the thesis submission.

Scientific issues

Qualitative research engages with in-depth study of a person's experience and is data driven with hypothesis generation, resulting from an exploratory approach to a phenomenon (Sciarra, 1999). In contrast, the dominant quantitative approach adopts a scientific inquiry defined by a positivist paradigm that encompasses a reductionist perspective and is theory-led through hypothesis testing.

Rigorous methodologies form an essential foundation of evidence-based healthcare (Biggerstaff & Thompson, 2008). Evidence-based practice is a dominant discourse in the NHS (Sackett et al., 1996). NICE guidelines are based upon comprehensive evidence for the best treatment and management of

particular disorders (Pilling, 2009). Although, Randomised Control Trials are not a monopoly, they are often credited for evaluating the efficacy of a particular drug or treatment. However, a qualitative approach offers the researcher the prospect of “developing an idiographic understanding of participants, of what it means to them, within a social reality, to live with a particular condition or be in a particular situation” and as such offers the opportunity to inform clinical practice (Biggerstaff & Thompson, 2008, p.178). Regardless of a quantitative or qualitative approach, both methodologies seek rigour in their application, although within qualitative analysis there are continuing disputes on how to achieve this and this has often been overshadowed by arguments to separate the guidelines from quantitative principles (Meyrick, 2006).

Giorgi (2010) questions the scientific soundness of IPA. His first criticism is levied at the non-prescriptive method (Smith & Osbourne, 2008) and the subsequent inability to evaluate the appropriateness of the methodology and replicate the study, thus limiting intersubjective understanding. Additionally he highlights contradictions with the approach which compromise the scientific rigor, namely the development of a strategy versus freedom for a researcher to deviate from this strategy. During this research project, I thought, particularly as a novice researcher, it was important for me to use the guidelines provided within IPA to assist my analysis, although these were used flexibly. I would envisage that as my qualitative research experience develops, I would naturally deviate from the guidelines and be more guided by my research and an approach that suited my research style. To ensure intersubjective understanding, I endeavoured to maintain an audit trail which would assist with transparency and detail how my analysis and interpretations corresponded to the raw data.

Finally Giorgi (2010) criticises the lack of instruction for researchers to comment on all the data and the absence of rules about what is commented on. He argues that when there are no justifications offered for selecting or discrediting data, then biases are likely to be occurring. In Smith’s (2010) rebuttal he argues that there is not total freedom within the approach and researchers need to adhere to “research steps” (p189) in addition to quality control criteria which encourages the researcher to undertake good qualitative work. Secondly, Smith contends that qualitative research is about replicability, instead he asserts this is

traditionally aligned with quantitative research and instead qualitative research should be evaluated using a criteria more applicable to its purpose (such as Yardley, 2000) rather than the impossibility of trying to replicate qualitative research which is a 'complex, interactive, dynamic process'. Although Giorgi (2010) raises some important criticisms about the scientific rigor with IPA (and potentially any other qualitative methodology) and the lack of clarity within the guidelines, I feel this could be easily resolved by the researcher being explicit and transparent. One such method is through checking the results of the study and how they were produced. During my research, I utilised supervision to check my analytical skills and have ensured that my research is presented in a way whereby others can check that the analytical stages have been described and evidenced.

Conclusions

The paucity and methodological limitations of previous literature investigating PSWs in the MH setting formed the rationale for the current study. This study provides an insight into the way in which NHS MH PSWs experience the transition into providing a service. Although the study sample was small, the method of analysis permitted the data to be explored in detail and resulted in the development of important superordinate themes. These themes all describe and interpret participants' experiences of the transition. Rather than the often oversimplified benefits and challenges delineated in the PS literature, this research has demonstrated that the interplay of a number of facets support or impede this transition but are also dependent on context and are variable. It is hoped that the emphasis of the current study on the complexity, individualistic and changeable nature of the role will develop an understanding for MH services about the importance of the enactment of the role being a process and reliant on the personal, interpersonal and collective identities assimilated with the position. Although the findings are not intended to be generalisable to the NHS MH PSW general population, they should be considered by professionals when working with this service and the impact their role has on PSWs and how the findings from this research could further develop understanding and inform practice.

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Appendices

APPENDIX A: Search strategy: Medline Example

The search was split into five parts, before being combined; firstly within the concept and then between concepts.

Split into five parts covering the topic of

- Peer
 - Support workers – also searched providers, specialists, counsellors, recovery support specialists
 - Training, work or employed
 - Mental health or mental illness
 - Adult
-

Example of search within Medline:

1. peer.mp.
2. exp Nursing Services/ or exp Community Health Aides/ or exp Nurses' Aides/ or exp Social Support/ or exp Societies, Nursing/ or exp Community Mental Health Services/
3. specialist.mp.
4. counselor\$.mp.
5. exp Stress, Psychological/ or exp Social Support/ or exp Adult/
6. 2 or 3 or 4 or 5
7. 1 and 6
8. employ\$.mp.
9. exp Work/
10. training\$.mp.
11. recruit\$.mp.
12. 8 or 9 or 10 or 11
13. 7 and 12
14. exp Mental Health/ or exp Mental Disorders/ or exp Community Mental Health Services/ or mental\$ ill\$.mp. or exp Adult/ or exp Stress, Psychological/
15. mental\$ health\$.mp. or exp Mental Health/
16. 14 or 15
17. 13 and 16
18. Adult/ or adult.mp.
19. 17 and 18
20. evaluat\$.mp.
21. 19 and 20

APPENDIX B: Consultation with key informants of the field: Email example

Hi Gemma. Pardon my delayed response. I have been away.

Attached is the one paper you requested and a book chapter that is "in press" that reviews the current CPS literature.

I cannot share the full report, but the brief report really includes the essential information.

Also attached are two articles I have written reporting results from a study of professional attitudes toward self-help groups. I use these results in discussions of likely professional attitudes and behaviors toward peer specialists. Please let me know if you would like to discuss this issue further.

Best, Mark

Mark Salzer, Ph.D.
Associate Professor and Director

APPENDIX C: Reflective starting points with qualitative research (Jones, 2004)

Box 2: Reflective starting points with qualitative research

The following is not a checklist of criteria, but rather, starting points for reflecting on qualitative studies and their usefulness (Jones, 2002):

1. How are the studies transparent and dialogical? Where is (are) the study's researcher(s) coming from? What are the backgrounds, prejudices and beliefs? (Professional as well as personal; e.g., gender, ethnicity, age, etc.) How are these limitations? In what way are these revealed?
2. How thoroughly is the research process described? Does the narrative include roadblocks, false steps, etc. described in a helpful way?
3. How are groups and individuals studied included in the larger research process? How are they involved in the research design? How are direct benefits to research participants included?
4. In what way is attention paid to the wider cultural context? For example, is the study of a minority group (age, ethnicity, class, etc) placed in context with the larger culture ('dominant' culture, majority, other age groups [e.g., youth/older people])?
5. How is the study presented as a narrative? How does the writing take the reader on a journey? Is it dialogical?
6. Is dissemination, more generally, part of the research design? How is feedback from both participants and the wider community included in the design and dissemination?
7. What are the main metaphors? How are they productive, engaging and explanatory? What specific attention is given to language and the construction of realities by use of language?
8. What are the studies bases in philosophical and theoretical ground? Are they transparent from the start?
9. How are ethical issues clearly delineated? Many of the proposed and emerging standards for quality in interpretive social science are also standards for ethics (Lincoln, 1995, p. 286). Lincoln discusses several issues in qualitative research that enlarge the debate about standards:
 - Problems of the face to face encounter
 - The virtual impossibility of maintaining anonymity under some circumstances
 - Selecting and excluding material to be included in case study
 - Open and honest negotiations around data collection, analysis and presentation.
10. Is it useful? In what imaginative ways might the study contribute to both a body of knowledge and society?

Appendix D: Personal correspondence with the editorial advisory board
(enquiring about an extended word limit for a qualitative study)

From: david.hunt@kcl.ac.uk
To: gemdyble@hotmail.com
Date: Fri, 2 Sep 2011 12:28:00 +0100
Subject: RE: JMH query
Hi Gemma,

Great - I cannot see that being a problem so would definitely encourage you to submit when ready. If you have any problems negotiating the manuscript central website please do let me know.

Kind Regards David

From: gemmadyble [mailto:gemdyble@hotmail.com]
Sent: 02 September 2011 11:57
To: Hunt, David
Subject: RE: JMH query

Thanks David for getting back to me so quickly.

I have to first submit my thesis to the university by the end of the month and then await feedback - so wouldn't be planning to submit to the journal for a bit. I would be aiming for a maximum of 6000 words including tables, references etc.

Kind Regards Gemma

From: david.hunt@kcl.ac.uk
To: gemdyble@hotmail.com
Date: Fri, 2 Sep 2011 09:49:57 +0100
Subject: RE: JMH query

Dear Gemma,

Many thanks for your email. We can have some flexibility and understand the issue with writing a qualitative paper and the current word limit. I would encourage you to still submit, though if you could give me an idea of the likely word count before submitting that would be great.

Kind Regards David

Appendix E: PSW job description and personal specification



NHS Foundation Trust

JOB DESCRIPTION

As an integral and highly valued member of the multi-disciplinary team, the PSW will provide formalised peer support and practical assistance to service users in order for them to regain control over their lives and their own unique recovery process.

Through sharing the wisdom from own lived experience, inspire hope and belief that recovery is possible in others. Within a relationship of mutuality, facilitate and support information sharing to promote choice, self-determination and opportunities for the fulfilment of socially valued roles and connection to local communities.

The PSW will take a lead role in embedding recovery values within the service setting in which they work, alongside other Trust Recovery Champions, and act as an ambassador of Recovery for the Trust with external agencies and partner organisations.

The PSW will promote their role, through the provision of information and a range of learning opportunities for the multi-disciplinary team and others across the Trust.

There is an expectation that PSWs will be involved in the ongoing development of peer roles in the Trust including the Peer Support Training Programme and evaluation.

As a core member of the multi-disciplinary team, the PSW will work alongside an agreed number of service users on a 1:1 and/or group basis for at least 60% of their time. They will also have the opportunity to co-work with other colleagues.

Reporting directly to the Team Leader/Ward manager and under the professional supervision of the Peer Support Worker Lead(s), the PSW will be responsible for the delivery of peer support interventions as agreed within the peer relationship and feeding into the CPA process.

PERSON SPECIFICATION

Organisation	
Post:	Peer Support worker
Band	3
Department:	Adult mental health

	Essential Criteria	Desirable Criteria
Education/ Qualifications	Good level of secondary education to GCSE level Level of educational attainment to NVQ 3 / AS Level or equivalent Completion of the Accredited Peer Support Worker Training Completion of own Wellness Recovery Action Plan (WRAP) or whole life plan	Related Health or Social Care qualification Willingness to undertake further training in line with the development of peer support

Experience	<p>Lived experience of mental health problems</p> <p>Wide range of life experiences to bring an enabling and positive view of opportunities for others.</p> <p>Experience of being in a supportive and enabling role</p> <p>Experience of working in a team or a group environment</p> <p>Experience of using a range of self-management or recovery tools and techniques</p>	<p>Psychiatric hospital admission</p> <p>Experience of working in the public sector</p> <p>Experience of training, teaching, coaching/mentoring others</p> <p>Experience of working across different organisational boundaries</p>
Skills/Abilities/Attributes	<p>Excellent written, verbal and non-verbal communication skills.</p> <p>Computer literate</p> <p>Willingness to learn the Trust's IT systems</p> <p>Able to relate to a wide range of people</p> <p>Professional in appearance and behaviour</p> <p>Able to manage conflict and to help others to do so</p> <p>Ability to maintain a healthy home/work life balance</p> <p>High level of self-awareness – ability to critically appraise own performance</p> <p>Critical thinker</p> <p>Ability to share personal story of recovery in a professional manner</p> <p>Ability to assist people to develop recovery plans</p> <p>Ability and willingness to reflect on work practice and be open to constructive feedback</p> <p>Ability to work in an enabling and creative way</p> <p>Willingness to support people with a range of needs to meet their recovery goals</p> <p>Ability to manage stress and to plan and prioritise work load</p> <p>Ability to carry out practical tasks</p>	<p>Presentation skills</p> <p>Computer literate in software applications such as Microsoft Word, Excel, Internet Explorer, Outlook Express etc</p>
Knowledge/Understanding	<p>Understanding and practical knowledge of recovery</p> <p>Understanding of the issues and concerns of mental health service users</p> <p>Knowledge and commitment to service users rights</p> <p>Understanding of the impact of stigma and discrimination</p> <p>Knowledge of Mental Health Legislation</p>	<p>Appreciation of the community resources within the geographical location of the post and key partners</p> <p>Understanding of CPA and the role of care co-ordinator and knowledge of Trust Policies and procedures</p> <p>Understanding of the service delivery goals of the care pathway</p> <p>Knowledge of local policies in respect of safeguarding children and the protection of vulnerable adults</p>

Appendix F: Cover letter sent out to participants

Transitions for Peer Support Workers in Mental Health Settings:

The Experience of Providing a Service

Hello,

My name is Gemma Dyble. I am currently training to be a Clinical Psychologist. Your Peer Support Co-ordinator has given you this information pack on my behalf. I would like to invite you to take part in my research study.

The purpose of my study is to explore your experience of being employed as a peer support worker. The aim of the study is to provide a unique opportunity for you to think and talk about your peer support experiences. It may also help service providers have a better understanding of what it is like and help inform policy and practice. Finally, it may help future individuals who provide peer support. The study will also form my Doctoral Thesis and will go towards my qualification as a Clinical Psychologist.

Please take the time to read the information sheet included. This will tell you a lot more about the study. If you would like to discuss the study further with me, please send the interest expressed sheet back to me with your contact details and a convenient time to be contacted. I will try my best to get in touch with you at this time. Alternatively if you prefer to phone or email, please feel free to contact me on **07971 813259**, or email me on **09160615@students.lincoln.ac.uk** and I will get back to you as soon as possible.

Thank you very much for your time.

Best Wishes,

Gemma

Trainee Clinical Psychologist/Chief Investigator of the study

Appendix G: Information sheet sent out to participants

PARTICIPANT INFORMATION SHEET

Transitions for Peer Support Workers in Mental Health Settings: The Experience of Providing a Service

Researchers: Gemma Dyble (Chief Investigator)
 Dr. Christine Collinson (Principal Researcher)
 Dr. Anna Tickle (Research Supervisor).

We would like to invite you to take part in our research. Before you decide we will explain why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the research if you wish.

Part I tells you the purpose of this research and what will happen to you if you take part. Part II gives you more detailed information about the research. Please ask us if there is anything that is not clear or if you would like more information. Details on how to contact us are available at the end of this information sheet.

PART I

1. What is the purpose of the research?

This research aims to understand the experiences of individuals with lived experience of mental health that provide a service for others with lived experience of mental health and what this transition is like. There have not been any previous studies looking into this subject; therefore the project aims to address this particular gap in the current knowledge. It is a unique opportunity to get your thoughts on this process, which could inform policy and practice. Furthermore, in the future, it could benefit other individuals who go on to provide peer support and offer better understanding as to what it is like to be a peer support worker. The research will also form my doctoral thesis which will go towards my qualification as a Clinical Psychologist.

2. Why have I been invited?

You have been invited to participate in this research because you have lived experience of mental health and now provide peer support. The research aims to recruit a maximum of 8 individuals.

3. Do I have to take part?

No. It is up to you to decide to join the research and if you do not want to, this will not affect you in any way. If you agree to take part, we will then ask you to sign a consent form, but you can still withdraw even if you get involved in the research. Further details are provided in part II.

4. What will happen to me if I take part?

Should you decide to take part, you will be invited to meet the researcher and talk about your experiences. The interview will go on for as long as necessary. It will last approximately one hour, but depends on how much you would like to share. It will be digitally audio-recorded. This is because we will need to write up the interview, word for word prior to beginning the analysis. The data (information from the interview) will be stored on a university computer and any identifiable information will be removed from the write up of the interview so you or anyone else you discuss cannot be identified from it. The data will be protected by a password and only we will have access to the information. Following this, the data will be copied on to a CD and kept in a locked filing cabinet at the University of Lincoln. All data files will be stored anonymously. The data that is gathered will only be viewed in full by the researchers. On submission of the Doctoral thesis quotes will be used directly from the data in the analysis, you or anyone you discuss, will not be identifiable from these quotes.

5. Expenses and payments

It is hoped that interviews will take place at your place of work, your home or any convenient location identified. Reasonable travel expenses will be paid to you if needed. For participating in the research you will also be offered a £10 high street voucher.

6. What are the possible benefits of taking part?

Although there may not be any direct benefit of participating in this research, this is a unique opportunity for you to think and talk about your experiences of using

mental health services and then providing one. By agreeing to take part in the research you may help service providers have a better understanding of what it is like to move from your own lived experience of mental health to providing a service for others and supporting their lived experience of mental health. In the future, this may also help others with experiences similar to yours.

7. What are the possible disadvantages and risks of taking part?

It is not thought that this research will cause you harm. Potentially the interview may provoke sensitive conversation and emotions. If this does happen you are free to take a break from the interview at any time, or stop the interview. Additionally, there will be an opportunity to have a follow-up session and speak to a clinical psychologist about your feelings following the interview.

8. What if there is a problem?

Any complaint about the way you have been dealt with during the research or any possible harm you might suffer will be addressed. Please see part II of this sheet for more information.

9. Will my taking part in the research be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part II.

If the information in Part I has interested you and you are considering participation, please read the additional information in Part II before making any decision.

PART II

1. What will happen if I don't want to carry on with the research?

All the data collected will be anonymised so you are not recognisable in the research. You can decide to withdraw at any stage of the research. You can withdraw prior to the interview, during the interview, immediately after the interview and up to 48 hours after the interview. If you decide to withdraw from the research after the interview, the data will not be used and this will not affect you in any way. All data will be safely stored and eventually destroyed.

2. What if there is a problem?

If you have a concern about any aspect of the research, please speak to the researchers who will do their best to answer your questions. The contact numbers are listed at the end of this information sheet. If you wish to complain formally about any aspect of the research, you can do this to [REDACTED] are Trust complaints [REDACTED] [http://www.\[REDACTED\]](http://www.[REDACTED])

3. Will my taking part in the research be kept confidential?

Any personal information collected from you will be stored in a locked filing cabinet at the University of Lincoln. This will be anonymous and coded. The demographic information collected will be used to provide information to the write up of the thesis only and will be locked away in a separate filing cabinet. The only time confidentiality would not be kept would be if you disclosed any information relating to harm to self or others, criminal activity or professional misconduct. In this situation, trust policies would be followed. Please also be aware that there are only a small number of peer support workers. This could mean that discussion within the team could lead to people realizing you have participated in the research. However, any information you provide will be anonymous.

4. Will any other health care professional be involved?

It is not necessary to seek consent from any other health care professional. However, feel free to discuss your participation with anyone who might give you independent advice.

5. What will happen to the results of the research study?

This research is a major part of the researcher's doctoral thesis and the results will be published in relevant journals and conferences. Within the published data, your personal

information will not be recognisable. If you are interested in the results, we will send you a summary report. Should you wish to be informed about the results of the research, please fill in the request form included in this information pack.

6. Who is organising and funding the research?

The research is organised and funded by the University of Lincoln.

7. Who has reviewed this research?

In order to protect your safety, rights, well-being and dignity, all potential research in the NHS needs to be checked by an independent group of people, called a Research Ethics Committee. This research has been reviewed and given favourable opinion by East Midlands Research Ethics Committee. It has also been reviewed by the research tutors at the University of Lincoln and Nottingham, an academic research supervisor and a clinical research supervisor in the NHS.

8. Further information and contact details

Should you want further information, please refer to the following:

- | | |
|--|--|
| 1. General information about research: | National Research Ethics Service:
www.nres.npsa.nhs.uk or telephone
 |
| 2. Specific information about this research project: | Miss Gemma Dyble (Trainee Clinical Psychologist) or Dr Christine Collinson (Consultant Clinical Psychologist) using the details below. |
| 3. Advice as to whether you should participate: | Friends, family, health care professional. |
| 4. Who you should approach if you are unhappy with the research: | Miss Gemma Dyble or Dr Christine Collinson.
Alternatively go to
 |

Chief Investigator
Gemma Dyble
University of Lincoln
Faculty of Health, Life & Social Sciences,
Court 11, Satellite Building 8,
Brayford Pool,
Lincoln
LN6 7TS
07971 813259
09160615@students.lincoln.ac.uk

Principal Researcher
Dr Christine Collinson
Nottinghamshire Health care NHS Trust
Westminster House,
598
The Wells Road,
Nottingham,
NG3 3AA
0115 9555360
Christine.Collinson@nottshc.nhs.uk

EXPRESSION OF INTEREST FORM

Peer support workers in mental health settings: the experience of transitioning into providing a service

I _____ (NAME)

would like to discuss the study further with Gemma Dyble.

My preferred method of contact is:

Please tick box and provide details

Telephone _____

☐

Email _____

☐

Post _____

☐

My preferred day or time to be contacted is

Please send this form back to Gemma Dyble, using the SAE envelope or give it back to your peer support coordinator. Alternatively if you prefer to contact me please feel free to call me on **07971 813259**, or email me on **09160615@students.lincoln.ac.uk** and I will get back to you as soon as possible.

Many Thanks Gemma (Chief Investigator)

Appendix I: Demographic information sheet

DEMOGRAPHIC INFORMATION

Peer support workers in mental health settings: the experience of transitioning into providing a service

Participant number _____

Age:	<input type="checkbox"/> I do not wish to disclose this
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> I do not wish to disclose this

I would describe my ethnic origin as:		
Asian or Asian British <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Any other Asian background Black or Black British <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background	Mixed <input type="checkbox"/> White & Asian <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> Any other mixed background White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background	Other Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group <input type="checkbox"/> I do not wish to disclose

In relation to your own mental health, which services have you had contact with?	<input type="checkbox"/> CAMHS <input type="checkbox"/> Early Intervention <input type="checkbox"/> Drug and alcohol <input type="checkbox"/> Recovery <input type="checkbox"/> Crisis <input type="checkbox"/> CMHT <input type="checkbox"/> Inpatient <input type="checkbox"/> GP only <input type="checkbox"/> None Other (please specify) _____ <input type="checkbox"/> I do not wish to disclose
If applicable, what year did you first enter a mental health service	<input type="checkbox"/> I do not wish to disclose
When did you start the peer support job?	<input type="checkbox"/> I do not wish to disclose
Please specify current or previous diagnostic labels you have been given	<input type="checkbox"/> I do not wish to disclose



National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 8839368
Facsimile: 0115 9123300

14 September 2010

Miss Gemma Dyble
Trainee Clinical Psychologist
NHS Lincolnshire Partnership Foundation Trust
DClinPys Course
Health, Life & Social Sciences
University of Lincoln, Brayford Pool
Lincoln, LN6 7TS

Dear Miss Dyble,

Study Title: Peer Support Workers in Mental Health Settings: The
Experience of transitioning into providing a Service
REC reference number: 10/H0406/60

Thank you for your letter of 01 September 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Investigator CV: Key Investigator		23 July 2010
Investigator CV: Chief Investigator / Student		23 July 2010
Investigator CV: Academic Supervisor		23 July 2010
Protocol	1	12 July 2010
Further Information Request Sheet	1	12 July 2010
Study Summary Request	1	12 July 2010
Expression of Interest Form	2	01 September 2010
REC application	50916/137537/1/465	23 July 2010
Covering Letter		12 July 2010
Letter from Sponsor		23 July 2010
Interview Schedules/Topic Guides	1	12 July 2010
Letter of invitation to participant	2	01 September 2010
Participant Information Sheet	2	01 September 2010
Participant Consent Form	2	01 September 2010
Response to Request for Further Information		01 September 2010
Questionnaire: Demographic Information	1	12 July 2010
Evidence of insurance or indemnity		06 August 2009
Referees or other scientific critique report: C. Collinson		
Referees or other scientific critique report: A. Tickle		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

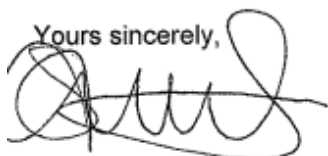
The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0406/60

Please quote this number on all correspondence

Yours sincerely,



Dr Carl Edwards
Chair

Email: [REDACTED]

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Mark Gresswell – University of Lincoln

R&D office for NHS care organisation at lead site [REDACTED]

Appendix K: Research and development approval letter

[REDACTED]

[REDACTED]

[REDACTED]

Date: 30th September 2010

Miss G Dyble
NHS Lincolnshire Partnership Foundation Trust
Health, Life and Social Sciences
University of Lincoln, Brayford Pool
Lincoln
LN6 7TS

Dear Miss Dyble

I am writing to confirm that the following study is authorised to take place within our Trust:

Title: Peer Support Workers in Mental Health Settings: The Experience of Transitioning into Providing a Service

Organisation /directorate(s): Adult Mental Health

Start Date: 30/09/2010 **End Date:** 31/10/2011

Outline:

A qualitative research project that will explore individual's subjective experiences of providing a peer support service. By interviewing participants, the aim is to explore their personal perceptions about both their experiences of the transition period from their lived experience of mental health to being employed as a peer support worker and its impact on their identity.

The participant will take part in a semi structured interview, lasting approximately 1 -1.5 hours and will take place at convenient time and place for the participant.

Honorary contracts/letters of access have been requested from the Trust HR department for the following members of your research team:

Name	Expiry Date
Gemma Dyble	31 st December 2010

Approval is dependent on a number of conditions, which are listed at the end of this letter.

In accordance with the Research Governance framework, The Trust RMG Department will request a progress update to assess its impact and influence on practice and policy. You will receive a brief progress report form to complete every six months from the start of your study which will provide you with the opportunity to inform us of any problems or concerns that you may have. We will also request a short summary of your research findings once the study is complete to assist in the dissemination process within the Trust

Appendix L: Ethics amendment letter

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court

Park Row

Nottingham

NG1 6GN

Tel: 0115 8839368

14 September 2010

Miss Gemma Dyble

Trainee Clinical Psychologist

NHS Lincolnshire Partnership Foundation Trust

DClinPys Course

Dear Miss Dyble,

Study title: Peer Support Workers in Mental Health Settings: The Experience of transitioning into providing a Service

REC reference: 10/H0406/60

Amendment number: 1

Amendment date: 01 September 2010

Thank you for your letter of 01 September 2010, notifying the Committee of the above amendment.

The amendment has been considered by the Chair who does not consider this to be a “substantial amendment” as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	Version	Date	
Participant Information Sheet	2	01 September 2010	
Notification of a Minor Amendment - further changes to the Participant Information Sheet following discussions with service users.	1	01 September 2010	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely,

Miss Susie Cornick-Willis

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Appendix M: University approval email

RE:

06/10/2010

Emile van der Zee

To gemmadyble

From: **Emile van der Zee** (evanderzee@lincoln.ac.uk)

Sent: 06 October 2010 19:10:49

To: gemma dyble (gemdyble@hotmail.com)

Hi Gemma, this is to confirm that you have ethics approval for your project from today. Good luck with the project; I hope that you get some interesting results, all my best,

- Emile

Emile van der Zee PhD
Principal Lecturer in Psychology
Programme Coordinator MSc in Child Studies
School of Psychology
Brayford Campus
University of Lincoln
Lincoln LN6 7TS
evanderzee@lincoln.ac.uk
<http://www.lincoln.ac.uk/psychology/staff/683.asp><<http://www.lincoln.ac.uk/psychology/staff/683.asp>>

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<http://www.lincoln.ac.uk/legal><<https://email.lincoln.ac.uk/exchweb/bin/redir.asp?URL=http://www.lincoln.ac.uk/legal>> .

Appendix N: Participant consent form

CONSENT FORM

Title of Project: **Peer support workers in mental health settings: the experience of transitioning into providing a service**

Name of Researchers: Miss Gemma Dyble – *Chief Investigator*

Dr Christine Collinson – *Principal Investigator*

Please initial box

1. I confirm that I have read and understood the information sheet dated 01/09/2010 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time before the interview and up to 48 hours after the interview, without giving any reason. ☐
3. I understand that my participation and all demographic/personal data obtained will be anonymised. ☐
4. I consent to audio recordings of the interview ☐
5. I agree to take part in the above study. ☐

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

STUDY SUMMARY REQUEST

Peer support workers in mental health settings: the experience of transitioning into providing a service

Please tick appropriate boxes

I _____(NAME)

1. do not require a summary or full report of the research

I have participated in

☐

OR

2. would like to receive a *summary* of the study once
complete.

☐

OR

3. would like to receive a *full report* of the study once
complete.

☐

If ticked boxes 2 or 3, please complete the following:

I would like to be sent this by

Post _____

_____(Address)

☐

OR

Email _____

☐

Appendix P: Debrief summary

DEBRIEF

Peer support workers in mental health settings: the experience of transitioning into providing a service

Thank you so much for taking part in my research, your time and input has been invaluable and I hope you have had a positive experience both with sharing your story and with the potential contribution it will make towards peer support research in England.

To highlight the importance and value of your contribution today, please accept this £10 gift voucher (for participants in receipt of state benefits, please be aware you may have to declare this as income and will need to check with the department of work and pensions. Gift vouchers of £5 do not need to be declared and could be an alternative).

The interview will form part of my doctoral thesis and when analysing the data I will be looking for key themes and concepts across all of the participants. Similarly, individual experiences will also be celebrated and as such some direct quotes will be used. However, names, places and any identifiable data will be anonymised in order to protect your identity and others.

After the interview you may think more about your experiences, if this causes you any distress there will be an opportunity to have a follow-up session and speak to a clinical psychologist about your feelings following the interview. Please get in touch with Gemma or your line manager if you request this.

Finally, you can withdraw from the research up to 48 hours after the interview. The data will not be used and this will not affect you in any way. All data will be safely stored and eventually destroyed. Please contact Gemma, Christine or your line manager if you would like to withdraw from the research.

All the best

Gemma Dyble
Chief Investigator

SEMI-STRUCTURED INTERVIEW SCHEDULE

Peer support workers in mental health settings: the experience of transitioning into providing a service

1. Can you tell me about what led you to getting this job?
2. Tell me about the experiences of becoming a peer support worker?
3. What was that experience like for you?
4. Has moving into this job changed the way you think or feel about yourself?
5. How do you think other people see you?
6. What do you think has influenced where you are now?
7. Tell me about how things are for you now?
8. How do you see yourself in the future?
9. Is there anything else you would like to say about your experiences or anything that I have not asked that you would like to talk about?

Prompts

Can you tell me more about that?

What sense did you make of that?

What was that like?

What do you mean by... ..?

What meaning did that have for you?


How did you experience that?

How did you feel about that?

What does it mean for you when you say.....?

Appendix R (A): Step 1 & 2: Reading, re-reading and initial noting -Conceptual, linguistic and descriptive comments for “Scarlet”

	Original Transcript	Exploratory Comments
545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581	<p>So I went out with the care coordinator, I went onto into [hospital] and onto the same ward where I was on and I was just like (...) "just don't focus on the door". Don't focus on the door" [laughs] and I was trying to think of all my techniques and you know distracting myself and you know really talking to the care coordinator and asking her loads of questions about all kinds of things and this is just a person, this is just a corridor, this is just a piece of floor! [laughs] this is just a chair. No this is not a ward, just don't think about the ward and I just had to really distract myself from (...) thinking "oh my god it's a ward, the doors are shut now, I can't get out (...) OH MY GOD. Are they going to let me out? [voice raises] Am I ever going to get out?" [laughs] You know I feel-, cos I really get claustrophobic as well. Erm, in wards, erm so erm-, yeah (...) it was an interesting experience. Erm-,</p> <p><i>In what ways was it interesting?</i></p> <p>It was freaky. Interesting is the polite word [laughs]</p> <p><i>What are the real words?</i></p> <p>The real words? It was scary, it felt-, my heart was racing, erm I felt trapped, erm and erm you know, I was just really struggling with rising panic and fear that was inside of me. But I kind of didn't freak out and didn't have a panic attack right there and night then which is all good. It doesn't do your whole professional image very good if you have a panic attack on the ward, but anyway. [laughs]</p> <p><i>Is that what you felt like doing?</i></p> <p>Yeah very much and erm we had an appointment with the doctor because obviously the care coordinator was supporting somebody on the ward, erm so starting a relationship and we had a-, god that was interesting, a really interesting-, sort of going in with the coordinator. There's me, the care coordinator and the doctor and erm and talking about a client and it just not being me. And it just, just being about somebody else and the sort of things they were talking about and it was just like-, I was just like "Oh god this feels really strange, [laughs] feels really strange" and I was looking out thinking "I used to be out there looking in here and ooooh different" [giggles]</p>	<p>Exploratory Comments</p> <p>Whilst on the ward trying not to focus on the door. <i>The door is symbolic of being locked up?</i></p> <p>Implements coping strategies i.e. distraction. <i>Focuses on anything but the reality of being on the ward</i></p> <p>Repetitive use of God – religious or the word is used to highlight the severity of the situation?</p> <p>Feeling claustrophobic</p> <p>Use of erm – struggles to articulate her thoughts and lack of fluency</p> <p>Repetition of interesting. <i>Why an interesting experience? It feels like a traumatic experience?</i></p> <p>Freaky <i>surreal experience?</i></p> <p>Scary experience. Panic and fear at being on the ward. Trapped. Managed her self – Delayed her panic attack</p> <p>Doesn't do your whole professional image very good if you have a panic attack on the ward – <i>sacrificed her personal needs for her professional needs?</i></p> <p>Starting a relationship with a RPS</p> <p>Use of word client, not peer or individual</p> <p>it just not being me patient to professional transition – strange = <i>difficult to comprehend she is no longer the patient? On the side of doctor & coordinator & then the client?</i></p> <p>Repetitive use of laughing- emotional response to the situation</p>

 – indicates repetition



– indicates quote used in thesis

Appendix R (A): Step 2- Extract on initial noting from reflective diary

“The step of initial noting is laborious but interesting. I’ve found the guidelines from Smith et al. (2009) particularly useful at the moment and keep checking that I’ve correctly understand the terms descriptive, linguistic and conceptual. It helps to reign myself in and remember that this stage is where I’m staying particularly close to my data. Using a colour code to break down the three discrete processes (red-descriptive/blue-linguistic/green-conceptual) allowed me to isolate phrases and sentences and keep track on my sense-making of the data and to ensure I was representing participant’s accounts. The conceptual level is where I’ve been able to bring in some psychological interpretation and move further away from the descriptive aspect. I’ve become particularly familiar with the reasons why bracketing my knowledge, preconceptions and influences are impossibilities. I caught myself being influenced by the environment the other day and making sense of my analysis through external stimuli. For example, I was in my car whilst on placement listening to the radio and the speaker spoke about social mobility and instantly I thought exactly that’s what my participant was doing. Again I had to reign myself in and stay with my data.”

Appendix R (B): Step 3- Developing initial themes

Initial themes	Original Transcript	Exploratory Comments
Coping as a process	545 So I went out with the care coordinator, I went onto into [hospital] and onto	Whilst on the ward trying not to focus on the door. <i>The door is symbolic of being locked up?</i>
Surviving the ward	546 door. Don't focus on the door [laughs] and I was trying to think of all my	
Reminder of patient identity	548 techniques and you know distracting myself and you know really talking to	Implements coping strategies i.e. distraction. <i>Focuses on anything but the reality of being on the ward</i>
Struggle to enact the role	549 the care coordinator and asking her loads of questions about all kinds of	
Surreal experience	550 things and this is just a person, this is just a corridor, this is just a piece of	Repetitive use of God – religious or the word is used to highlight the severity of the situation?
Panic and fear at being on the ward	551 floor! [laughs] this is just a chair. No this is not a ward, just don't think about	
Managed her self – didn't have a panic attack	552 the ward and I just had to really distract myself from (...) thinking "oh my god	Feeling claustrophobic Use of erm – struggles to articulate her thoughts and lack of fluency
patient to professional transition	553 it's a ward. the doors are shut now. I can't get out (...) OH MY GOD . Are	
Peer support being a relationship	554 they going to let me out? [voice raises] Am I ever going to get out?" [laughs]	Repetition of interesting . <i>Why an interesting experience? It feels like a traumatic experience? Freaky surreal experience?</i>
sacrificed her personal needs for her professional needs	555 You know I feel-, cos I really get claustrophobic as well. Erm, in wards, erm	
Professional identity	556 so erm-, yeah (...) it was an interesting experience. Erm-,	Scary experience. Panic and fear at being on the ward. Trapped. Managed her self – Delayed her panic attack
Strangeness of transition	557 <i>In what ways was it interesting?</i>	
	558 It was freaky. interesting is the polite word [laughs]	Doesn't do your whole professional image very good if you have a panic attack on the ward – <i>sacrificed her personal needs for her professional needs?</i>
	559 <i>What are the real words?</i>	
	560 The real words? It was scary, it felt-, my heart was racing, erm I felt trapped,	Starting a relationship with a RPS <i>Use of word client, not peer or individual</i> it just not being me patient to professional transition – strange = <i>difficult to comprehend she is no longer the patient? On the side of doctor & coordinator & then the client?</i> Repetitive use of laughing- emotional response to the situation
	561 erm and erm you know, I was just really struggling with rising panic and fear	
	562 that was inside of me. But I kind of didn't freak out and didn't have a panic	
	563 attack right there and right then which is all good. It doesn't do your whole	
	564 professional image very good if you have a panic attack on the ward, but	
	565 anyway. [laughs]	
	566 <i>Is that what you felt like doing?</i>	
	567 Yeah very much and erm we had an appointment with the doctor because	
	568 obviously the care coordinator was supporting somebody on the ward, erm	
	569 so starting a relationship and we had a- god that was interesting , a really	
	570 interesting -, sort of going in with the coordinator. There's me, the care	
	571 coordinator and the doctor and erm and talking about a client and it just not	
	572 being me. And it just, just being about somebody else and the sort of things	
	573 they were talking about and it was just like-, I was just like "Oh god this feels	
	574 really strange , [laughs] feels really strange " and I was looking out thinking "I	
	575 used to be out there looking in here and ooooo different" [giggles]	
	576	
	577	
	578	
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	580	
	581	

Appendix R (B): Step 3- Extract on developing initial themes from reflective diary

“I began to identify initial themes in my left-hand column, with the verbatim transcript being central to the analysis and the right-hand column depicting the three discrete processes. It’s fascinating to see the analysis taking form and to see the original data now next to my thoughts and interpretations. It’s helpful to be able to view the three columns simultaneously and ensure I am not misrepresenting what was originally said by the participant. Some of the themes felt relatively comfortable and mapped very closely to the raw data. However other themes were laced much more with my interpretation and didn’t sit as comfortably. Nevertheless it represents the “I” in IPA and as long as I didn’t fall into the trap of over interpreting then I was doing IPA justice. Again this is where supervision and keeping a good audit trail is essential.”

Appendix R (C): Step 4- Searching for connections across initial themes:

Numeration of initial themes (before collapsing) “Scarlet”	Frequency
Acceptance – team member rather than stigmatising her	II
Alternative ways of working/modelling change	II
Amalgamated self	I
Anti-medical approach/model /Anti-psychiatry	V
Back-to-work ethos	II
Barrier to change	I
Barriers to accessing services	I
Being asked what PSW was and explaining- Lack of role clarity	I
Being heard	I
Being recognised and valued	I
Building connections with already established PSWs	I
Challenge the problems of the service in a productive way	III
Challenge to NHS/SERVICE/TRUST/system failure/lacking	X
Changed identity	II
Choosing how to describe lived experience	III
Collaborative working	I
Committed purpose/aims for PSW	I
Commonalities with professionals	V
Compromise with differences	I
Conflicts with staff that were previously part of her care	I
Coping abilities	I
Creating choices for people	II
Developed confidence	I
Difference of opinion between PSW and staff	I
Different perspective on the role of PSW	I
Different perspectives on professionals’	I
Discharged with little support	I
Empowerment and control	III
Establishing why they don’t want to move with the movement	I
Experience as a journey	I
Experience of first day	III
Expert by experience	I
Expressing sympathy for other professionals	I
Family support and having confidence in her abilities	I
Feeling vulnerable	I
Flexible with time off -	I
Flexible, accommodating and open team	I
Forced help	I
Giving back	I
Group belonging	II
Healing process	I
Hope	II
Importance of allowing time for the transition of being an end user to the provider	I

Importance of service user involvement	I
Institutionalised nature of the team	III
Institutionalised nature of the ward	I
Joint working with people	I
Lack of job security for other professionals/ impeding on their career path/threatened	III
Language barrier – recovery vs. medical	II
Last minute knowledge of PSW from care coordinator	I
Limited options	I
Loss of rights (patients)	I
Lost identity	I
Managed the situation through self-talk and taking control of her worries	I
Masked professionals	I
medical model/pathologising	III
Mutual support	I
Normalise language and experiences	I
Not alienate yourself,	I
Acceptance by the service at the expense of society	I
Not a mutual relationship	I
Not able to cope with the situation	I
Not sure how others see PSW	I
Others protecting professional identity at the expense of promoting personal agency	I
Others recognising her skills	I
Overreliance on services – encourage institutionalisation/service identity	I
Overlap of patient-professional role	I
Panic and fear at being on the ward	I
Part of developing the service	I
Passion to work in service she'd received care from	III
Patient identity	I
Personal growth\Personal growth within the PSW service \being open	VIII
Person-centred approach	I
Placing value on her choices and desires	I
Positive agents of change	I
Practical issues of notes	I
Problems of theory to practice	I
Problems with going on the wards	I
Promoting agency in others/independency	I
Promoting peer support	III
Professional identity	I
Providing a different perspective for recipients of PSW	I
Providing different stories	I
PSW – interview process supportive	I
PSW- recovery angle rather than medical	I
PSW service overprescribed	I
PSW success	I
Readdressing the power imbalance	III
Really important to hold onto part of yourself	I

Recognition of importance of PSW	II
Recognition of own judgements and preconceptions	I
Recovery focused/orientated	I
Recovery too theoretically based	II
Re-establishing identity	I
Re-establishing relationships/social networks	V
Reintegration back to work – needed it to be a slow process	II
Relationship being key was able to listen and respect her. Two-way relationship?	II
Responding well to feedback	III
Re-traumatised being on the ward	I
Role-reversal	I
Sacrificed her personal needs for her professional needs	II
Service development	I
Services become your family and then reject you	I
Services can be damaging/traumatic	II
Sharing success stories/her journey/ being a role model?	III
Some staff threatened by change	II
staff responding to her- professional-patient role	I
Strangeness of transition	I
Stronger sense of self	I
Struggle to enact role	I
Support from team and family\peer support	IV
Support recipients to rebuild their identity	II
Supported own recovery	II
Surreal experience - patient to professional transition	I
Survive the system/ System works against you	II
Taking on a task to help out the care coordinator because of that guilt	I
Talk about taboo stories such as children and MH	I
The power of others believing in you	I
Usefulness of variety	I
Ward: = daunting/scary/overwhelming/wrong?	II

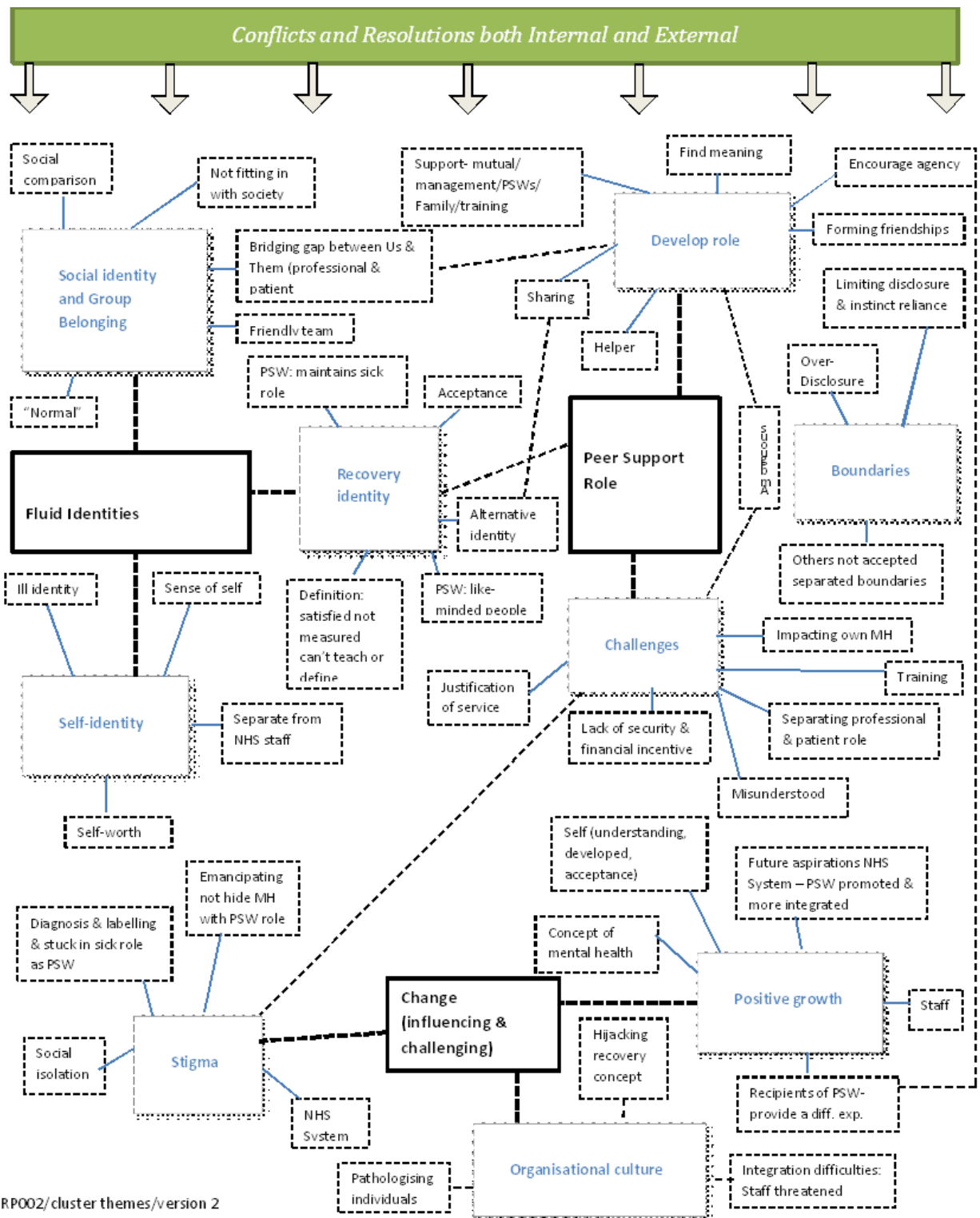
Appendix R (C): Step 4- Searching for connections across initial themes: Subsumption table – clustering themes

Super-ordinate	Subordinate	Initial
Fluctuating Identities	Loss	<ul style="list-style-type: none"> • Lost identity
	Recovery and Positive change	<ul style="list-style-type: none"> • Back-to-work ethos • Developed confidence • Different perspectives on professionals - Encouraged to see other professionals having similar views – normalising experience • Empowerment and control • Family support and having confidence in her abilities • Healing process • Giving back • Group belonging • Own recovery improved • Personal growth\Personal growth within the PSW service - has enabled her to be open rather than reacting and being defensive • Recognition of own judgements and preconceptions • Stronger sense of self • Supported own recovery
	Acceptance	<ul style="list-style-type: none"> • Accepting her into the team • Group belonging • Experience as a journey • Others recognising her skills • Self - Sharing personal story = powerful tool
	Changing Social Identity and previous self	<ul style="list-style-type: none"> • Identity as a professional rather than patient • Importance of allowing time for the transition of being an end user to the provider • Amalgamated self • Changed identity • Positive agents of change • Really important to hold onto part of yourself • Aligning with professionals - Seeing as 'normal' and having similar struggles • Surreal experience - patient to professional transition • Work transition – long absence of work

Conflicts, resolutions and resignations: Peer Support Role	Differing motivations of becoming a PSW	<ul style="list-style-type: none"> • Building connections with already established PSWs • Committed purpose/aims for PSW /Closure for self • Lack of confidence that other employers would have made reasonable adjustments/supported her? • Last minute knowledge of PSW from care coordinator • Limited work options • Looking for change in own life – Particular aspects encouraged that motivation • Passion to work in service she'd received care from
	Role certainty, role vagueness and role difficulties	<ul style="list-style-type: none"> • Develops the relationship between patient and professional – sharing the power/decision making • Flexible • Normalise language and experiences • Promoting agency/independence in recipients of PSW • Re-establishing identity (for recipients) • Re-establishing relationships/social networks • Reintegration back to work – needed it to be a slow process • Relationship focus • Not sure how others see PSW • Being asked what PSW was and explaining- Lack of role clarity • Different perspective on the role of PSW • Sacrificed her personal needs for her professional needs • Re-traumatised being on the ward - Panic and fear = Managed the situation through self-talk and taking control of her worries
	Philosophical Distinctiveness and practical ambiguity	<ul style="list-style-type: none"> • Share experiences • Person-centred approach • Desire to work in a certain team/potential dilemma of working there and simultaneously receiving care • Mutual support • Promoting agency in others/independency • Providing a different perspective for recipients of PSW - Providing different stories • Readdressing the power imbalance • Witness to hope and change • Recovery focused/orientated • Recovery too theoretically based
Conflicts, resolutions and resignations: Cultural change	Medical Vs Recovery approach	<ul style="list-style-type: none"> • Anti-medical approach/model/Anti-psychiatry • Expert by experience • Language barrier – recovery vs. medical • medical model/pathologising • Problems of theory to practice – professionals feeling they know more because

		<p>of education</p> <ul style="list-style-type: none"> • PSW- recovery angle rather than medical • Way of working prevents recovery
	Attitudinal support and Attitudinal barriers	<ul style="list-style-type: none"> • Supportive project coordinator, team and family • Flexible, accommodating and open team • Being listened to, recognised and valued • Being part of the system to change it • Collaborative working/shared values • Experienced professionals being real people – finding shared experiences • Finding joint meaning with staff • Complement each other – PSW & team • Compromise with differences • Coping abilities • Influencing other professionals perspectives by sharing her story • Team open to the idea a PSW working there & simultaneously receiving care • PSW success = PSW service overprescribed with team referrals • Recognition of importance of PSW • Creating choices for people • Changing the culture NHS/SERVICE/TRUST • Challenge the problems of the service in a productive way to influence change • Challenge to the system - lack of resources. Lack of support available, teams and resources stretched • Challenging the NHS system – failure of the system • Battling/fighting the system /Unhelpful system/damaging • Services become your family and then reject you • Survive the system/ System works against you • Institutionalised nature of the team/ward • Others protecting professional identity at the expense of promoting personal agency • Peer support can be seen as threatening • Language getting in the way • Tension over jobs and problems it could create • Conflicts with staff that were previously part of her care • Different perspectives on professionals' • Lack of job security for other professionals and impeding on their career path • Overreliance on services – encourage institutionalisation/service identity • Power imbalance

Appendix R (C): Step 4- Searching for connections across initial themes:
Spider diagram. “Lucy’s” example



Appendix R (C): Step 4- Scarlet's transcript extract indicating theme discarded due to it not being related to the actual transitional experience.

Theme: Examples of future ideas for the peer support

"Erm is that my hope and ambition is that when people first have a dis-, not obviously, it might not be the first, but have like a stressful period where they know they need some kind of support. First person, usually people most have contact with is their GP. Go to the GP say this is going on right? If at that point, the GP goes "oh there's this service and it's made up of people who have had distressful periods in their lives, would it benefit? Would you like meet up with somebody? [Shouts] They're in that room down there! [laughs]. You know I can put you in touch with them. I can get them to ring you. Are you happy for me to do that?" And that person says "yes please" [laughs] And they see the Peer in the GP clinic and we, you know, have sort of some time and have nice comfy sofas and tea and biscuits. Erm and just like oh my god, what a different face to mental health services, that person would come into contact with. You know, peer being alongside and being mutually supportive. Erm can kind of have such a resource of different things, obviously be trained in facilitating recovery. What best support they could offer that person, right from the start. Not wait until they get to secondary services but dealing with it while it's still in the community, you know but being so unthreatening cos god what's the thing that stands out in your mind if somebody says "I'm going to refer you to the crisis team." It's not good is it? [laughs] But being with somebody who's been-, in a way been through a distressful period, I think would combat anti-stigma, stop that person thinking "oh my god, mental health services! That means I've got a mental health condition that means I'm mental. Oh my god!" You know [laughs] but if you can stop that, reduce-, not even stop it, cos I don't think we can stop it completely but reduce it to what it potentially can be if that person didn't have contact at that time. Erm god it would change the outlook, change, you know, if they did need more support from the services there first entry point, oh I don't like entry point, I don't like entering into mental health services, but their first access or first contact with services, would be on a positive foot. And how much better to establish a relationship when its on positive and go from strength to strength. Erm and in the long term vision would to have a peer that would support that person through different stages if that person did need that support, some people do. If that person needed more support from different areas of the service, that peer would stay with them and be continuum, be continuous through that obviously that peer that person really really well and would be able to feedback and advocate from a lot stronger position as well, about the needs and requests, being able to do things, like the recovery pack and write it at an early stage "What do you want? What are your needs, what would you like to happen?" And for that piece of paper to be taken and used in different meetings and multi-disciplinary meetings and that's my long term mission (...) What do you think?"

[both laugh] You answered my questions? Way down there.

OK

So we might come back to it. You're not short of ideas are you?

Appendix R (C): Step 4- Extract on searching for connections across initial themes from reflective diary

“Wow what an overwhelming task. I’m flooded with initial themes. Too many. It has certainly been an arduous process of trying to organise the data into superordinate themes. I initially used numeration. This wasn’t to put a number on the data but helped me delete repeated themes and cluster overlapping ones together. Subsumption came next to identify patterns across the initial themes. It was peculiar to see the themes all clustered together to form a subordinate theme and then a series of related subordinate themes brought together to form a superordinate theme. Although I can still trace the route of the initial theme and can often remember what was actually said to support this theme. This was made easier when graphically viewing it in a spider diagram.

The difficulty with some themes was where to place them because some straddled subordinate themes and even superordinate themes. It was a decision of where the data best fit or whether I needed to collapse themes even further. This process was particularly challenging.

When considering which themes to discard I went back to my research question. Although the data was full of interesting and worthwhile reporting, some of it didn’t relate to the transitional experience. Alternatively some of the data could be used as single-cases and although there was a lot of convergence in the data (which I mainly focused on) there was a considerable amount of divergence.

Appendix R (D): Step 5 and 6- moving to the next case and looking for patterns across cases

Subordinate themes and ordinate themes	Participants:							
	Peter	Lucy	Simon	Nadia	Hannah	Pauline	Scarlet	Total
1.1 Changing Social Self								7
1.1.1. Additional Identity	✓	✓			✓		✓	5
1.1.2. Role model	✓		✓	✓	✓	✓	✓	6
1.1.3. Group Belonging	✓		✓	✓	✓		✓	5
1.1.4. Overlapping roles	✓	✓	✓	✓	✓	✓	✓	7
1.2. Recovery, growth and acceptance								7
1.2.1. Reconnecting, recovering an taking control	✓	✓	✓	✓	✓		✓	6
1.2.2. Not hiding self		✓	✓	✓	✓	✓		5
1.2.3. Barriers to re connecting, recovering and taking control	✓	✓				✓	✓	4
2.1. Role Certainty								7
2.1.1. Sharing and mutual support	✓	✓	✓	✓	✓		✓	6
2.1.2. Person-centred	✓	✓		✓			✓	4
2.1.3. Promoting autonomy, acceptance and meaning	✓					✓	✓	3
2.1.4. Inspiring hope and recovery	✓	✓	✓	✓	✓	✓	✓	7
2.2. Role vagueness and difficulties								7
2.2.1. Vagueness, inventing role and changeable	✓	✓		✓	✓	✓	✓	6
2.2.2. Impacting on own well-being		✓	✓			✓	✓	4
2.2.3. Tricky and out of my depth		✓		✓	✓	✓		4
2.2.4. Role stigma	✓	✓		✓		✓		4
2.3. Boundaries and disclosures								7
2.3.1. Clear boundaries and disclosures	✓	✓	✓	✓	✓			5
2.3.2. Blurred boundaries and disclosures	✓	✓	✓	✓	✓	✓	✓	7
3.1. Changing the system								7
3.1.1. Paradigm shift: from medical to person-centred	✓	✓	✓	✓	✓	✓	✓	7
3.1.2. Experts by experience		✓	✓				✓	3
3.1.3. Challenge to the system		✓		✓	✓		✓	4
3.1.4. Agents of change	✓	✓	✓			✓	✓	5
3.2. Attitudinal support and barriers								7
3.2.1. Level of staff acceptance	✓	✓	✓	✓	✓		✓	6
3.2.2. Support within peer support		✓		✓	✓	✓	✓	5
3.2.3. Stigma getting in the way of empowerment	✓	✓	✓		✓	✓	✓	7

Appendix R (D): Step 5 and 6- Extract on looking for patterns across cases from reflective diary

“And I thought the stage of bringing one transcript together was tough, looking for patterns across the cases has again been a painstaking process and I’ve found myself constantly changing my mind and rearranging the themes. I again looked for support within the Smith et al. (2009) book which advocates a questioning process to support the examination across the themes of individual participants. Again supervision was particularly important at this stage of analysis to ensure my organisation of the data was justified and could be accurately traced back to the raw data. It was really useful just to sound out my thoughts and interpretations and sketch out the relationships between the themes with another person. There has been a lot of email communication. Again I have been careful to view this as strengthening my analytical skills and tracing my decision-making process, not a form of triangulation. An example of the usefulness of supervision was emphasised with my keenness to have two core themes underlying the themes: *relationship with stigma* and *relationship with recovery*. To me these core themes really seemed to permeate the whole data. However, when my supervisor asked me to look into this more closely and evidence it within the raw data, it just wasn’t strong enough to warrant separation from the other superordinate themes.”